			State of Maryland / Department	artment of Health and I rtificate of Death			27001
			Registrar  1. Decedent's Name (First, Middle, Last)	incate of Beatif	Reg.	NO.	3. Time of Death
18 th	Physici	an	Curtis R. George			1, 2006	5:45a <sup>M</sup>
1	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Examir	er	Laurelwood Care	E1kton		Cecil	
1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Q Righ	nplace (State or Foreign
4	Director		214-26-1733 15xM 2 F 76 Yrs.	Months Days Hours Min.	October 12,1	929	MD
	2		Usual Residence of Decedent				10d. Inside City Limits
	arylar show	_	10a. State 10b. County 10c. City, Town or Lo	Cation			1 1 Yes 2 □ No
	18a-f	Director	MD Cecil Elkton	10/ 7: 0:4:	100	Citizen of What Co	
	Mith ti		100. Street and Number	10f. Zip Code			uritry ?
	s 23	era	109 Walnut Lane  11. Marital Status 12. Was Decedent Ever in U.S. 13. V	21921 Was Decedent of Hispanic Origin? (S		.S.A.	ncan Indian.
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, it a Medical Examinat must be malified at	by Funeral	Armed Forces?	if Yes, specify Cuban, Mexican, Puert 1 □ Yes 2  No <i>Specify:</i>	o Rican, etc.)	Black, White Specify: Whi	e, etc.
21215-0036	hour tural			dent's Usual Occupation	166	b. Kind of Business/l	ndustry
5	in 72	Completed	(Specify only highest grade completed) (Give	kind of work done during most of wor DO NOT use retired)	rking		
212	r the	E		y Treasurer	G	overnment	
ਰੂ	I be filed value Hygie of other I	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Nar	ne (First, Middle, Mai	den Sumame)	
<u>a</u>	uld by Aenta rrked tic s	To E	Ralph George	Harrie	tt Jones		
Maryland	2 sho and 2 Is me	- 19	19a. Informant's Name/Relationship ( <i>Type</i> , <i>Print</i> ) 19b. Mailir	ng Address (Street and Number or Ru	ıral Route Number, C	ity or Town, State, Z	(ip Code)
≥	and neelth n 27			ne Carr St., Elk		1921	
ore	Jes 1 If ital		1 L Burial 2 Noremation 3 L Hemoval from State	matory or other place)		c. Location - City or	
Ë	ment tant: tury		4 Donation 5 Other (Specify) R.A. Ferr			st Cheste	er,PA
Baltimore,	permit. Peges 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic so once.		A	2. Name and Address of Facili 200 andrew G. Gee Fund	eral Home	01001	
* 1	H		23a. Part1. Enter the disease or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardia	Elkton, MD or respiratory arrest	21921	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CIRRITOSIS			Onset and Death
A.	/Medical		resulting in death)  a. Due to (or as a consequence of):				
	Examiner		Sequentially list conditions b. END STAGE	Liver Dz			
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	ecute and trans	Examln	that initiated events	00			
8760,	icate be executed physicien and s the burial-transit	E	resulting in death) Last Due to (or as a consequence of):				
87	physi the t	dical	d				
9 ×	ding	(D)	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	ivea
Вох	The law requires that the death certifi ate has been signed by the attending l page 2 should be detached for use as	Physician/M	in the past 12 months?	Ectopic pregnancy Other (specify)		Month	Day Year
P.O.	the d y the	ysi	1 Yes 2 No 9 Unknown	,,			
σ.	res that igned b be deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
g .	n sign				1 🗆 Yes	2□No 3□Pr	obably 4 Unknown
ပ္ပ	law requir as been si 2 should l	Completed			24a. Wasan	24b. Were au	topsy findings available
æ	The la te ha	E			autopsy performe 1 ☐ Yes -2€	d? death?	completion of cause of
ta	sician: The la certificate ha rector, page ?	0	25. Was case referred to medical	26. Place of De	ath (Check only one)		
<b>&gt;</b>	<u>~ ∞</u> ¬	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatien	nt 3 DOA Other: 4 Nursing I	dome 5 ☐ Residenc	e 6 □Other (Spe	cify)
0	ng Ph Iter th		27. Manner of Death  1 Natural 5 □ Pending (Month, Day Year)  28b. Time of Injury (Month, Day Year)	f 28c. Injury at Work?	28d. Describe how	injury occurred	
Sio	Attending ir death. ector; After by the fune	catl	2 Accident investigation	M 1 Yes 2 No			
	or Ati	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not le determin = 2 le. Place of Injury - At home, farm, stribuilding, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
_	pital		29a. Certifier Certifying Physiqian: To the best of my knowledge, deat	h occurred at the time, date and place	and due to the caus	se(s) and manner as	stated
	To the Hospital or Attending Physicial & Abrous attendesth.  To the Funeral Director: After the completely filled in by the funeral	edical	(Check only 2 Medical Examiner: On the basis of examination and/or in one)				
	vithir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Mont	h, Day, Year)
			· / / / ///	D54073	1	4 AUG 6	06
35			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		11 1.	1 - 1 - 1 - 1 - 1 - 1 - 1
	10		Asien Brut in 8	11) CHIZCHMAN	s CTR	- Menla	37LE 176 1974
3000 1000 1000	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 1 4 2006	D54073 Print) D240 Park		,	
M. M.	Regist	ar	TOUT I TOUGHT TO Y				

			1 - For State Registrar		Maryland /		artmen rtificate					Rag.	10	06	271	002
r	Physici	an	Decedent's Name (First, Middle								2. Date of Month		Day	Year	3. Time	of Death
	/Medic		Jean Ashlei								Aug.	10,			6:21	. a <sup>M</sup>
	Examir	ier	4a. Facility Name (If not institution	•				_	Location	of Death				ty of Death		
		8	Laurel Regio			A tak at		irel	If Under	24 Hrs	0.000		Prin		orge's	
(8)	Funeral Director		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. last	Vrs.	Months		Hours	Min.	8. Date of (Month)	f Birth J. Day, Year) 9. Birthplace (Stete or Foreign Country) Alexandria, VA				
			578-30-0462 Usual Residence of Decedent		79					L	12/2	//19	20	ATEX	aliuria	, VA
	yland 10w		10a. State 10b. County		10c. City, To	own or L	ocation								10d. Inside	City Limits
	Mar.	to	Maryland Howar	d	Laur	e1									<b>₹</b> ☐Ye	s 2 No
	or 28	ire	10e. Street and Number				10f. Zip	Code				10g	. Citizen o	f What Cou	intry?	
	72 hours after death with the Maryland neturel', or Items 23a or 28a-f ehow Jisal Examiliar must be netified at	Funeral Director	10714 E Cresty	view			2	0723					USA			
	- dea	iner	11. Marital Status	12. Was Dece Armed For	dent Ever in U.S.	13.	Was Deced	ent of Hi	spanic Ori	igin? (Sp	ecify Yes o Rican, etc.	r No-		ace - Amer lack, White	ican Indian,	
98	or it	J. Y	1 Never Married 2 Mar	ied 1 ☐ Yes	2 <b>K</b> No e		1 ☐ Yes 2		Specify:			,		ify: Wh:		
21215-0036	urel',	d by	3 ☑ Widowed 4 □ Divorced													
5	"net	lete	15. Deceden (Specify only highe	t's Education st grade completed)		(Give	dent's Usua kind of wor DO NOT us	k done o	lurina mos	t of work	ing	16	b. Kind of	Business/I	ndustry	
12	withi ene. then	m d	Elementary/Secondary (0-12)	College (1	-4or 5+)		cher	, , , , , , , , , , , , , , , , , , , ,	,				Sta	ıte.		
9	filed Hygi other	ပိ	17. Father's Name (First, Middle,	Last)					18. Moth	er's Nam	e (First, Mic	ddle, Ma				
an	id be ental ked c	To Be Completed	William Carl	Padgett					Ma	rgar	et Sm:	ith				
Maryland	2 should be filed within 72 hours aft and Mental Hygiene. is marked other than "neturel; or aumatic event, the Madical Exemitations."	-	19a. Informant's Name/Relations	hip (Type, Print)	1	9b. Maili	ng Address	(Street a			al Route No		ity or Tow	n, State, Z	ip Code)	
	nd 2 alth a 27 is		Sheila Saville	- Daughte	er	1071	4 E C	rest	view	La	urel.	MD	207	23		
ē,	s 1 a of Hear item othe		20a. Method of Disposition	/	20b. Place	of Disp	osition (Nan	ne of			Date				Town, State	
E	Page nent c nt: If		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation /5 ☐ Other (S		State Ft. ]	Linc	matory or or of old Co	emet	ery	8/12	2/06	Br	entw	ood,	Maryla	and
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydiene. Important: If Item 27 is marked other than "neturel; or Items 23s or 28s-f show way injury or other traumatic event. It a Madical Examinar must be nutified at once.		21. Signature of Juneral Service	May											, P.A. 20781	
	* .%		23a Part). Enter the disease, or	complications that ca	aused the death. D									-, III	Approxim	ate
400	Physician		shock, or heart failure. List Immediale Cause (Final disease or condition resulting in death)	a. Cer	ebral thr		sis								Onset and Minut	d Death
	/Medical Examiner		rooming in odding		or as a consequence			1		1	14					
		ē	Sequentially list conditions, if any, leading to immediate	D	erioscler		cere	BLOV	ascu	Lai	ursea	se			Years	
	on sit	듵	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<												
Ć.	execting and items	Examiner	that initiated events resulting in death) Last	Due to (	or as a consequence	ce of):										
8760,	sate be executed physician and the burial-transit	dicai		d												
9	ntifica ng ph as th	1 (0)	IC COMMIT											-		
Box	eath certific attending pt for use as t	an/A	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy irth 2  Fetel dea		∃Ectopic pr	egnancy						ate of deli	,	3/
	e dea he at ted fo	sici	in the past 12 months? t □ Yes 2 ☒ No		ant at time of death		Other (sp						,	<b>M</b> onth	Day	Year
P.0	that the de ted by the a detached f	Physician/M	9 Unknown						: E 4		22- 5	Old Anhan			4b	i danth?
Records,	taw requires that the death certificate be executed as been signed by the attending physician and . 2 should be detached for use as the burial-transit	Completed by	Part II. Other significant condition Hypertension		nath but not resulting	g in the t		ause give	n in Parti				2 No		the cause of bably 4%	
၁၁	e taw re has bed ge 2 sho	plet	Type 2 diabe	etes melli	tus							Vas an lutopsy	24b	. Were aut	opsy finding	s available
	e e	E O									F	erforme es 2X		death? 1 ☐ Yes	2 No	Cause of
ita	ician: Th certificate rector, pag	Be	25. Was case referred to medica examiner?						26. Place	of Deat	h Check o	nly one)				
of Vital	Physician: this certific ral director,	ည	1 ☐ Yes 2X No		npatient 2 ER/				4 🗆 140	ursing Ho	me 5 🗆 F	Residenc	e 6 □O	ther (Spec	ify)	
n o	ding P	ü	27. Manner of Death 1 X Natural 5 ☐ Pendir	28a. Date of (Monti	of Injury h, Day Year) 28t	D. Time o		8c. Injury Work			28d. Descr	ibe how	injury occ	urred		
Sio	Attending r death. actor: After oy the fune	cati	2 Accident investi 3 Suicide 6 Could	not he			М		∕es 2□	No	00/ 1				15	
Division	or All	Certification:	4 Homicide determ	ined 286. Place	of Injury - At home, ng, etc. <i>(Specity)</i>	, tarm, st	reet, factory	, office				Town, S		nger or Hu	ral Route Nu	mber,
-	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1⊠ Certifyia	ng P <b>hysician</b> : To the	best of my knowled	doe, dea	th occurred	at the tim	e. date ar	nd place.	and due to	the caus	se(s) and r	manner as	stated	
	te Hora	edical	(Check only 2 Medical one)	Examinar: On the ba and mann	sis of examination	and/or in	vestigation,	in my op	oinion, dea	ith occur	red at the ti	me, date	and place	e, and due	to the cause	(s)
	To th To th comp	ž	29b. Signature and title of certifie	1 11	_		290	. License	number	0 11	,	29d	Date sign	ned (Month	, Day, Year)	
			Willia	m/t/	anen	N		(1)	159	16	)	A	uga	110	1200	96
D	1251		30. Name and address of person	· ·									4			
/ -			William A.Wa		Prince G		ge St.	, La	urel	, MD	2070	)7				
	Sta Registi		AUG 1 1 20		egistrar's Signature	free	U									

		1	For State Registrar	State of Maryland	•		f Health and of Death		giene Reg. No.	006	27003
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Yeer	3. Time of Death
	Physicia /Medic		Elai	ine A. Hughes				August	10	2006	1115 A M
	Examin		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Tow	m, or Location of De	ath	4c. Co	unty of Death	
			102 Abbott Drive			E1kt				Cecil	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Y Months Da	ear If Under 24 H ays Hours M	in. (Month, Da	h y, Ye <i>ar)</i>	Coun	
П	Director		212-28-1536	<sup>4 2</sup> ₩ 80	Yrs.			May 17,	1926	Mary	land
	9	. ⊢	Usual Residence of Decedent	10e City	Town or Loc	antion				1	0d. Inside City Limits
	phow	<u>ا</u> ـ ا	10a. State 10b. County			Jation				,	1 ∑Yes 2 ☐ No
	Ba-fe	cto	Maryland Cecil	ETK	ton	1			100 03:00	of What Coun	
	or 2	Director	10e. Street and Number			10f. Zip Co					
	23a	La l	102 Abbott Drive			219		(0	T	ed Stat	
	r de	Funeral	11. Maritai Status	. Was Decedent Ever in U.S. Armed Forces?	. 13. V	Yas Decedent Yes, specify	of Hispanic Origin? Cuban, Mexican, Pu	erto Rican, etc.)	. 14.	Black, White,	
98	or afte	by Fi	1 Never Married 2 Married	1 ☐ Yes 2 📜 No If Yes, Give	1	☐Yes 2🏋	No Specify:		Sp	pecify: Bla	ck
ë	ural'		3 ☐ Widowed 4 ☒ Divorced	Year or Dates:	16a Decer	lent's Usual O	ccupation		16b Kind	of Business/Inc	
က်	72	Completed	15. Decedent's Educa (Specify only highest grade		(Give	kind of work d	one during most of a	working		ed Stat	
7	withii	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)	Foo	d Serv	ice		Gove	rnment	
2 2	Hygir ther		17. Father's Name (First, Middle, Last)	1				Name (First, Middle	Maiden Su	mame)	
an	ntal od o	Be	Clarence C. Fitts				Glad	ys B. Hy1	and		
2	should be filed within 72 hours after deeth with the Maryland and Mental Hygiene.  narked other then "netural", or iteme 23e or 28e-f ehow omatic event, I'm Medical Examinar must be notified at	ဥ	19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailin	g Address (Si	treet and Number or	·		own, State, Zip	Code)
Z Z	d 2 s th an th an treu		Jeffrey K. Hughes			-	Drive, El				
Baltimore, Maryland 21215-0036	Heal Heal tem 2		20a. Method of Disposition	20h Pla	ce of Dispo	sition (Name	of	Date		tion - City or To	wn, State
0	nt of nt of t: If it		1 Burial 2 Cremation 3 Re	moval from State Hock	essin	Crema	tory Aug	gust 21,	Hocke Delaw		
틀	it. Printing in the ritant		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee		any	. Name and A	∠UU ddress of Facility_			arc	
Ва	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heath and Mental Hygiene.  Important: If item 27 is marked other then "netural", or iteme 23a or 28a-f show eny injury or other treumatic event, it a Medical Examinar must be notified at ance.  and once.		March Mi	bas Edward	H3	icks Ho	ome for Fu Stockton S	nerals, l	A.	Marula	and 21021
			23a. Part1. Enter the disease, or complic	ations that caused the death.						Tial y 10	Approximate
			shock for heart failure. List only one Immediate Cause (Final	a cause on each line.						0	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)			c la	movas		1800	~	20
	Examiner			Due to (or as a conseque	ence or):						
		<u></u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):						
	ted nsit	듵	cause. Enter Underlying Cause (Disease or injury								
	and al-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):						-
8760,	the death certificate be executed y the ettending physicien and sched for use as the burial-transit	alE									
687	icate phys s the	dical	a.								
×	eath certific ettending pl	Physician/Me	IF FEMALE:	c. If yes, outcome of pregnan	су				236	d. Date of deliv	вгу
Вох	etter etter for u	cla	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea		]Ectopic pregi ] Other <i>(speci</i>				Month	Day Year
o.	that the de ed by the detached	ysi	1 □ Yes 2 MNo 9 □ Unknown	9☐ Unknown							
۵.	that if ed by detac	4	Part II. Other significant conditions conf	ributing to death but not resul	ting in the u	nderlying cau:	se given in Part I.	23a. Did	tobacco use	contribute to t	he cause of death?
ds	The law requires that ste hes been signed b bage 2 should be deta	d by						_ 10	Yes 2💢	No 3∏Proi	oably 4 □Unknown
Š	w requir been si should	Completed						24a. Was	an	24b. Were auto	opsy findings available
3ec	hes hes	ם						— auto		prior to co death?	mpletion of cause of
a								1 Tes	2 2 No	1 🗌 Yes	2)K No
Z:	certific rector,	Be	25. Was case referred to medical examiner?	ospital:			Other	Death (Check only		70 (0	4.1
ō	this al di	2	1 Yes 2 No	1   Inpatient 2   E	R/Outpaties 28b. Time o		4   Nursir	ng Home 5 Res			ry)
5	ding I h. After funer	0	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	м	linjury at Work? 1 ☐ Yes 2 ☐ No				
18	ten leat tor: the	Ca	3 Suicide 6 Could not be	28e. Place of Injury - At hor	ne. tarm. st	reet factory o	office	28f. Location	Street and	Number or Rur	al Route Number,
Division of Vital Records,	efter d efter d Direct d in by	Certification:	4 ☐ Homicide determined	building, etc. (Specify)		,,,		City or To	wn, State)		
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune		29a. Certifier 1 Certifying Phys	ician: To the best of my know	vledge, deat	h occurred at	the time, date and o	lace, and due to the	cause(s) a	nd manner as :	stated.
	24 h Fur etely	Medical	(Check only 2 Medical Examinone)								
	of this of the office of the o	Me	29b. Signature and title of certifier			29c. l	icense number		29d. Date	signed (Month,	Day, Year)
	- × - 0		9 Nilder 50	Muslan MP		D	00597	23	Uugu	st 11	2006
			30. Name and address of person who co	moleted cause of death (Item	23a) (Tvne	Print)					
	3		Melchor E. Madar		Nov	th Str	eet Juite	C Elk	ton.	MO 2	1921
	St	ate	31. Date filed (Month, Day, Year)	32. Resistrar's Signat	ure	1 .					
L	Regist		AUG 1 1 2	106 Kleever.	D. A	pour					

			1 - For State Registrar	State o	f Marylan		artment of H rtificate of I		l Mental Hyg	giene 2 (	106	2700
	Physici	an	1. Decedent's Name (First, Middle, La Edna Mae Ho						2. Date of Dea Month August	9 <sup>Pay</sup> 200	Year	3. Time of Death 2315 M
)	/Medic Examin		4a. Facility Name (If not institution, giv		nber)		4b. City, Town, or	Location of De		4c. County		2313
	LXdiiiii		Carroll Hospital	Center				stminst		Ca	arrol	.1
	Funeral Director		214-30-3320	ex □M 25a1F	7. Age (In yrs. 65	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		1940	Cour	place (State or Foreign htry) 11and
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	a-f eh	ctor	Maryland Carro	11			We	estminst	er			1 ☐ Yes 2 🔀 No
	h with the	Funeral Director	10e. Street and Number 1174 Dingus Drive	2			10f. Zip Code	21158		10g. Citizen of V US		ntry?
2	fler deel	Funer	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Fo 1 ☐ Yes	2 <b>万</b> №	'	f Yes, specify Cuba	in, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race Blac	e - Americ k, White,	
	hours a urel', o	þ	3 Widowed 4 Divorced	If Yes, Giv Year or D	/e ates:		1 ☐ Yes 2 ☑ No	Specify:		Specify		hite 
612	within 72 ene. then "nat	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12		-4or 5+)	(Give	dent's Usual Occupi kind of work done o DO NOT use retired Manager	durina most of w	vorking	Senior		<i>'</i>
מנומ	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other then "naturel", or Itame 23a or 28a-f show aumatic event, the Madical Examinar must be notified at aumatic event, the Madical Examinar must be notified at	To Be Co	17. Father's Name (First, Middle, Last, Lester Ernest H						ame (First, Middle, thy Culver		Θ)	
Maly	od 2 shoulth and M	-	19a. Informant's Name/Relationship ( William Dean Hoop		band		-		Rural Route Number Jestminste	•	-	Code)
נֵ ס	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene.  Importment of Health and Mental Hygiene.  Importment if them 27 is marked other than "naturely or itame 23a or 28a-f show eny injury or other traumatic event, the Madical Examinar must be notified at once.		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specif		State	emetery, cren	sition (Name of natory or other place roll Cren	atory 0	Date 08/11 2006	20c. Location - Winfi	•	
Dall	permit. Departm Importa eny Inju		21. Signature of Funeral Service Lice	1588	M011	J 1	Name and Addres		Myers-Dur Westmin	boraw F	uner	al Home
			23a. Part . Enter the disease, or com shook, or heart failure. List only	plications that c	aused the deat		<del></del>		<del></del>	<u>.</u>		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. 11			-ADDER	- CAI	JCER			Onset and Death
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5	Physic this or rat dire	မ	1 ☐ Yes 278 No 27. Manner of Death	Hospital: 128a. Date	npatient 2	ER/Outpatien		4   Nursing	Home 5 Resid			()
5	nding f ath. r: After te funer	ation	1 Natural 5 Pending 2 Accident investigation	(Mont	h, Day Year)	Injury	Work	rat (? Yes 2∐No	20d. Describe III	ow injury occurr	<b>3</b> 0	
2	el or Attending Physician: The is effer death.  I Diractor: After this certificete his din by the funeral director, page	Certification;	3 Suicide 6 Could not b 4 Homicide determined	289. Place	of Injury - At hong, etc. (Specify	ome, farm, stre	eef, factory, office		28f. Location (S City or Town		er or Rura	l Route Number,
	To the Hospitel or Attendi within 24 hours effer death. To the Funerel Director: A completely filled in by the to	Medical (	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Example	niner: On the ba	best of my kno asis of examina ner stated.	wledge, death tion and/or inv	n occurred at the time vestigation, in my op	ne, date and pla pinion, death oc	ce, and due to the c curred at the time, d	ause(s) and mai late and place, a	nner as st	ated. the cause(s)
	To the comp	ž	29b. Signature and title of certifier	lad			29c. License	number	2	9d. Date signed	(Month,	Day, Year)
1	MIL		The same of	unc			1026	,855		8,1	0	06
	6		\$9. Name and address of person who FARHAD SAT	ERI	M.D	295	Print) STONER	- AVEN	JUE M	estmik	1578	R MD
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 1 1	2006 32. R	Sistrar's Signa	ture	book					,

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 08 Day 4:05 PM **Physician** 2006 10 BETTY MAY HEDDINGER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner QUEEN ANNE'S 216 LONG POINT ROAD STEVENSVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 K F Yrs 12/09/1932 PA Director 213-28-6232 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hem 27 is marked other than "netural", or Itama 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director QUEEN ANNE'S STEVENSVILLE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 216 LONG POINT ROAD USA 21666 death y Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. ant: if Item 27 is marked other than "netural", or Ite 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Yes 2 No Specify Completed by 3 X Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DISTRICT COURT 12 OFFICE CLERK 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be EARL RAYMOND FITEZ LULA MAY BOLLINGER ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 906 CLARK'S CORNER RD., CENTREVILLE, MD 21617 JOHN HEDDINGER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō ± 5 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: if any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE CEMETERY 08/14/2006 STEVENSVILLE, MD 21. Signature of Eunera Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or comshock, or heart failure. List only tions that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, or complic Immediate Cause (Final disease or condition resulting in death) ANCIZEMTIC CANCER Physician Month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregpant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 mod Month Day Year 5 Other (specify) been signed by the should be detached 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has le 2 autopsy performed ir this certificete has ☐Yes 2☐No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only ope) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 1 Yes 2 No ၀ 5 Tresidence 6 ☐ Other (Specify 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending 1 🗌 Yes investigation death after death I Director: / Id in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D completely filled i 29a. Certifier 🛮 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29d. Date signed (Month, Day, Year) and title of certifier 29c. License number 29b. Signature 01 D37064 of person who completed cause of death (Item 23a) (Type, Print) 30. me and addre Chamberland Hoint Rd. Stevensville, Md 21666 130 Love 45 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Spark AUG 1 4 200b Registrar

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			1 - For AMEND#23a per Phy Stata Registrar AACO HEALITH DEI					nd Mental Hy	-	6	27006
	w **		1. Decedent's Name (First, Middle, Last)		Cel	unicate o	Dealli	2. Date of De		7	3. Time of Death
*	Physici		Milton Griscom J					Month		ear	2:35 A M
	/Medio		4a. Facility Name (If not institution, give			4b. City, Town	, or Location of I		4c. County of		2:33 A
		1	Anne Arundel Medi	cal Center		Anna	apolis		Anne	Arun	nde1
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs.		If Under 1 Year Months Day	ar If Under 24	Hrs. 8. Date of Bin Min. (Month, Da	th 9		ace (State or Foreign
ngo	Director		008-14-5194 Usual Residence of Decedent	79	Yrs.			Min. (Month, Da 11/21,	/1926	Penn	sylvania
	be filed within 72 hours after death with the Maryland stal Hygiene. od other than "natural", or iteme 23a or 28s-f ehow avent, the Madical Expruirser must be nutified at	'n	Maryland Anne Aru		y, Town or Lo dgewat					10	0d. Inside City Limits
	28a-f	Funeral Director	10e. Street and Number			10f. Zip Code	-		10g. Citizen of Wha	at Count	
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	death	nera		12. Was Decedent Ever in U. Armed Forces?	S. 13.			? (Specify Yes or No Puerto Rican, etc.)			
90	or its	y Fu	1 Never Married 2 Married	1∭XYes 2⊡No lfYes.Give		ilos, specily ci		dello ricali, etc.)	Specify:	White, e	hite
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pu	be filed tal Hygi d other svent,	Bec	17. Father's Name (First, Middle, Last)					Name (First, Middle,			
yla	should tind Ment	5	George Eugene					lelen Gris			
Maryland	s 1 and 2 should if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty Frances K. Jaques					or Rural Route Number Edgewate:			Code)
ore,	of Hear		20a. Method of Disposition	20b. P	Place of Dispo	sition (Name of natory or other p	nlace)	Date	20c. Location - Cit	ty or Tov	wn, State
Ë	nit. Pages entment of ortant: If i injury or		1 ☐ Burial 2 【X Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	MALITORI STATE	las Cre	ematory	8-	-10-06	Edgewat	-	
Baltimore,	permit. Pages 1 Depertment of H important: if ite any injury or ot		21. Signature of Euneral Service License	99				George P. land Rd. I			
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ord	w requir been si should		The Two fo	2010 12	47074		Car	101	/es 2 □ No 3[	] Proba	ibly 4 □Unknown
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<u>ra</u>	icien: Th certificete rector, pag	ပိ	25. Was case referred to medical					1 ☐ Yes	200 No 1		2□ No
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100	ng Ph ter th		27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In			now injury occurred	Specily)	
sio	Attending r death. ector: After by the fune	catle	2 ☐ Accident investigation				□Yes 2□No				
Division of Vital	i or Attend after death Director: , d in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory, offic	е	28f. Location (S City or Tox	Street and Number on, State)	or Rural	Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	Medical C	29a. Certifier Certifying Physical (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the vestigation, in my	time, date and p opinion, death	place, and due to the occurred at the time,	cause(s) and manne date and place, and	er as sta I due to	ited. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	N. des registeres .		29c. Lice	nse number		29d. Date signed (A	Month, D	Pay, Year)
			moly And	Wifer South	Y	D	433	71	8/9/	2	
	11 01		30. Name and address of person who co	empleted cause of death (Item	23a) (Type,	Print)			1/10	,	0
	121		Jet Dy 11 Jes EPH 31. Date filed (Month, Day, Year)	- ITEX BELT	A	nne of r	render	mod Ctr	· 2001.11	ED.	PRRY.
-46 s	Sta Registr			32. Ragistrar's Signa	IN A	book		Mod Ctr			

State of Maryland / Department of Health and Mental Hygiene [1] [ 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician PEGGY JOHNSON 0807AM 2006 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner TENINALA NICOMICO KEDIONOL SAUSOU Medical Year If Under 24 / 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🕱 F 214-28-3624 75 Director 1931 Maryland 28, Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State item 27 is marked other then "neturel", or items 23a or 28a-f show other traumatic event. The Madical Examinar must be notified at Marion Station 1 ☐ Yes 2 🗗 No Maryland Somerset Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21838 U.S.A. 27518 Farm Market Road Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 XMarried Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ă 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Processing Assembly 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental I Pages 1 end 2 should be Margaret Howard John Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27518 Farm Market Road - Marion Station, MD 21838 Item 27 Calvin B. Johnson (Husband) Important: If item any Injury or other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Crisfield, MD Sunnyridge Mem. Park 8/17/06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bradshaw & Sons Funeral Home <u>306 W. Main St.- Crisfield, MD</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pticemia Je **Physician** day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown comentia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t irector, page 2 s autopsy performed? 2□ No 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: the t 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funerel Direct completely filled in by filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) ۽ 29h. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00064152 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Division St, Ste 301, Phionae 1390 5 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 1 5 2006 Glow It Goods

		For State Registrar	State of Marylan		artment of rtificate of			iene 1g. No.2 0 0	6 2700:
Physicia		Decedent's Name (First, Middle, Last)     Betty Ann Johnson					2. Date of Death		aar 3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give SALISBURY REHAB &	street and number)	iR	,	or Location of Deat	h	4c. County of WICOM	Death
Funeral Director	8	220-26-1526	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Yea Months Days			Year)	b. Birthplace (State or Foreig Country) MD
death with the Maryland The 23s of 28s-f show Thurst be notified at	tor	Usual Residence of Decedent           10a. State         10b. County           MD         Wicomic		y, Town or Lo					10d. Inside City Limit
with the a or 284 Liberrot	Director	10e. Street and Number 32796 Willomet Cou	arct.		10f. Zip Code 2184	10	10	0g. Citizen of Wh. USA	•
Z shoud be lied within 72 hours affer death with the Marylan and Mential Hygiene. and Mential Hygiene. ie marked other then "naturel", or iteme 23a or 28a-f show eumatic event, it a Modical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Black,	American Indian, White, etc. Black
ene. then "natur ta Medical	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occi kind of work don DO NOT use retir	e during most of wo. red)	rking	School	ness/Industry  Cafeteria
item 27 ie marked other then other treumatic event, Ita M	To Be Co	11 17. Father's Name (First, Middle, Last) Willie Henry Denni	is	ASS	SISCAIL I	18. Mother's Na	me (First, Middle, M Jane Spen	Maiden Surname)	Careteria
In and r		19a. Informant's Name/Relationship (Ty Marigold S. Morris			Commission of the Commission o	et and Number or Ru			ate, Zip Code)
Department of Health a Important: if item 27 is eny injury or other tre once.		20a. Method of Disposition  1 Donation 5 Other (Specify)	Removal from State	lace of Dispo emetery, crea	sition (Name of matory or other pl	ace)	Date	20c. Location - Ci Berlin,	
Importa eny inju once.		21. Signature of Funeral Service Licens		22   I	2. Name and Add		neral Ho	me	
/sician ledical aminer is the burial-transit	edical Examiner	23a. Part1. Enter the disease, or complished, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):	colo,	n Ca,	na		Interval Between Onset and Death
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ctor: After this of the funeral dir	Certification: T	27. Manner of Death  1	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inj		28d. Describe ho	w injury occurred	
Completely filled in by the I	ledical Certifi	4 Homicide determined  29a. Certifier 1 Certifying Phy	28e. Place of Injury - At he building, etc. (Specifical Programs of the best of my known iner: On the basis of examina	y) wledge, deat	h occurred at the	time, date and place	City or Town	n, State)	or Rural Route Number,
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician August 15, 2006 1:25 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reeders Memorial Home Boonsboro Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗑 F Director 214-32-4569 71 April 18 1935 Hagerstown Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location worle 10d. Inside City Limits r then "natural", or items 23s or 28s-f ehov the Medical Examinar must be excitled at 1 Yes 2 □ No Director Maryland Washington Boonsboro 10e. Street and Numbe 10f. Zin Code 10g. Citizen of What Country? 141 S. Main st 21713 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No tf Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2/2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other then 10 Certified nursing Assistant Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental I Kunkleman Adelaide Hewett Pau1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2
wit of Health ar.
int: if item 27 ie r.
v or oth-67 Manor Dr. apt. 201 Hagerstown Maryland 21742 Michael Leon Jordan / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
eny injury or ott 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 8/21/2006 Hagerstown, Maryland Rest Haven Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between tmmediate Cause (Final disease or condition resulting in death) Physician Luy 2 2 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a porsequence of) Examiner physicien and the burial-transit The law requires thet the death certificate be executed Due to (or as a consequence of) Physician/Medicai attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 26. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Ulriknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ≱ a. Was an hes autopsy performed? 1 Yes 2 No 1 Yes 2 No Be director 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No this After this funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours aft To the Funeral Di completely filled in Medicai 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) - tout mo 018019 AUKUST 16, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Vasant Datta 340 Mill St. Hagerstown, MD 21740 (301)739-7100 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 2 5 2006

**ORIGINAL** 

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Records,

Division of Vital

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Registrar		eg. No.	06 2701
Physici Medical Exami		1. Decedent's Name (First, Middle,Last)  Kevin Michael Johnson	2. Date of Dear Month August 11	Day Year	3. Time of Death 1600 hrs
		4a Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of De	
		Howard County General Hospital Columbia  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1 If Under 24Hrs	To a constant	Howard	
Funeral Director		213-84-2625   1XM 2F   34 Yrs.   Months Days Hours Min.	-	For	Birthplace (State or eign Country) Maryland
any		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
<u> </u>	JO.	MD Caroline Federalsburg			1 X Yes 2 No
ith the Maryland 23a or 28a-f show s notified at once.	I Director	10e. Street and Number 317 Buean Vista Avenue 21632		Og Citizen of What C Inited St	
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leaft and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-fish trammatic event, the Medical Examiner must be notified at once	Funeral	11. Marrial Status 1  XNever Married 2  Married 12. Was Decedent Ever in U.S Armed Forces? 1  X Yes 2  No 3  Widowed 4  Divorced If Yes, Give Year 1  Yes, Specify Cuban, Mexican, Puerto		White, etc	
urs afte tural"	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of w	vork done	Specify 16b Kind of Busines	White
36 hin 72 bo e. than "na dical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retirementary.  11 Machinist	red)	Pewter	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last) 18.Mother's Name		,	
2121 Duld be fi Mental I marked	o Be			Newman	
MD 2 shoulth and I is a sumatic	υ	Donnette E. Newman/Mother 2207 Kings St., Lync	hburg,	VA 24501	
F = 5 = 7		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b Place of Disposition (Name of cemetery, crematory or other place)  Mid-Shore Crem.Ctr 8/	Date 21/06	20c. Location - City Cambride	or Town, State
Baltimc permit Page Department Important: injury or otl	1	21. Signature of Funeral Service Licensee  Christine M. Coale  Pederalsburg, Fr.	amptom	Funera1	Home, P.A.
Physician		23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	v 2163	2 est shock or heart	Approximate Interval
/Medical Examiner		failure List only one cause on each line.  Immediate Cause (Final disease a. Narcotic intoxication	roopiratory arre	ot, orlock, or riedit	Between Onset and Death
)		or condition resulting in death)  Due to (or as a consequence of):			<u> </u>
المعجوب ا	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			-
3760, ficate be executed g physician and s the burial - transit		d.		·	
50, te be ex sysician sburial	n/Medical	X UNPENDED  item#23a.27.28a-f.perME.g858.8/29/06  IF FEMALE:  23c. If yes outcome of prepagatory	TT		
68760, ertificate bo ding physic e as the bur	an/N	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnal	ncy	23d Date of deliver	ery Day Year
that the death certificated by the attending detached for use as	Physicia	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown 9 Unknown		6	
P.O. Es that the gned by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
IS, P.C quires that en signed !	ed by				obably 4 V Unknown
Division of Vital Records, tal or Attending Physician: The law require rs after death al Director: After this certificate has been sided in by the funeral director, page 2 should be	Completed		24a. Was a autop: perfor	sy prior to	autopsy findings available completion of cause of
Re( r: The lificate or, page		25 Was case referred to medical 26 Place of Death (Check of	1 ✓ Yes 2		
Vital F hysician: ' this certific	o Be	examiner?		Residence 6 Ott	ner.
ding Ph	$\vdash$	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c Injury at Work?		ow injury occurred	
isior Attend or death rector: by the f	catic	Natural 5 Pending Pend	unk		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use as	Certification:	determined (2)	28f. Location (S or Town, St Jessup, M	ate) 7555 Wat	Rural Route Number, City erloo Road
e Hosp 124 hou e Fune etely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the cause	e(s) and manner as st	arted
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated  29b. Signature and title of certifier 29c. License number	t the time, date a		
	=	29b. Signature and title of certifier  29c. License number  O.C.M.E.		29d Date signed (N August 12, 200	
.a.d	, l	30 Name and address of person who completed cause of death (Item 23a)			
1 Not bring		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	l		
St Regist	ate trar	31 Date filed (Month, Day, Year) AUG 2 5 2006 32. Registrar's Signature			

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

			1 - For State Registrar	State of M	larylan	d / Depa		of Health	and M		jiene Reg. No.	2006	27011
	Physici	an	Decedent's Name (First, Mid							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic		SYDNEY	S.		OZIEL				AUG	8	2006	2:00 P M
	Examin	er	4a. Facility Name (If not institut					wn, or Location	n of Death		4c. 0	County of Death	
1		<u> </u>	ATLANTIC G.  5. Social Security Number	ENERAL HOSPIT		ast birthday)	If Under 1 Y	ERLIN	er 24 Hrs.	8 Date of Birt	1	WORCES'	
	Funeral Director		169-32-8307 Usual Residence of Decedent	1□M 2፟ØF	65		Months Da	ays Hours	Min.	8. Date of Birtl (Month, Day APRIL 9			place (State or Foreign ntry) VSYLVANIA
	Maryland		10a. State 10b. Cour	ty	10c. City	, Town or Lo	cation						10d. Inside City Limits
	a-f s	ctor	MARYLAND WOF	CESTER		OCEAN	CITY						1 X Yes 2 □ No
	ith the	Director	10e. Street and Number				10f. Zip Co	ede			10g. Citiz	en of What Cou	ntry?
	ath w	rai	13207 ATLAN					21842				USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28a-f show ary injury or other traumatic event, the Medical Evantical must be facilified at	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ M  3 🛣 Widowed 4 ☐ Divorc	If Vac Giva	? LNo X		Was Decedent f Yes, specify ( 1 ☐ Yes 2 🔯	_		ecify Yes or No- Rican, etc.)		4. Race - Americ Black, White, Specify: WH	etc.
21215-0036	2 hou	ed	15. Deced	ent's Education	-	16a. Dece	dent's Usual O	Occupation		1	16b. Kin	d of Business/In	dustry
215	hin 72	piet	(Specify only high Elementary/Secondary (0-12	nest grade completed)	54)	(Give	kind of work d DO NOT use re	lone during mo etired)	ost of work	ing			,
21	d with	Completed	12	, College (1 40)	31,	CI	JSTODIA	N			PH	ARMACEU'	rical
and	ld be file ental Hy rked oth	To Be C	17. Father's Name (First, Middle BERNARD	e, Last) SHAW	S	R.			her's Nami HELEN	e (First, Middle,	Maiden S A •	,	KSON
DOD-S s 2000 1400 ■ Baltimore, Maryl	sho and h is ma		19a. Informant's Name/Relatio	nship (Type, Print)		19b. Mailir	ng Address (St	treet and Num	ber or Run	al Route Numbe	r, City or	Town, State, Zip	Code)
ς Σ	and 2 salth n 27 i		BERNARD SHAW/	BROTHER					R., D	AYTONA	BEAC	H, FLOR	IDA 32128
b o	es 1 of He if iten		20a. Method of Disposition	n 3 □Removal from State		ace of Dispo metery, crer	sition (Name on natory or other	of r place)		Date	20c. Loc	ation - City or To	own, State
ii 3	Pag ment ant: I		`4 □ Donation 5 □ Other			NWOOD	MEM. G	GARDENS	8/1	4/06	BRO	OMALL,	PENNSYLVANI
Sall	ermit.		21. Signature of Funeral Service	se Licensee		2000	. Name and A			V 12:000		-i-i-i	21.0100-2011
ă II	₫ O E ® O		- (Kailer	Vertical								LLE, DE	. 19975
4			23a. Part1. Enter the disease, shock, or heart failure. L	or complications that cous- ist only one cause or each	ine.	. Do not ent	er the mode of	f dying, such a	is cardiac	or respiratory an	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a	100	505							Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or as	s a consequ	ence of):	11	(-	1	21000			
- 8		-	Sequentially list conditions,	b. 10551	りて	11771	4 450101	MIW 4	1 /	nces			
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>₹</b> 5 Due to (6) a.	s a consequ	erice or,.			V				
	al-trai	xar	that initiated events resulting in death) Last	C. Due to (or as	s a consequ	ence of):							
M41 8760	ate be executed hysician and the burial-transit	icai E											
	certificate nding phys Ise as the	edic		d.									
DOE: OH OO P.O. BOX 6	that the death certifice ed by the attending ph detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			35-4				23	3d. Date of delive	ery
O m	death e atten	icia	in the past 17 months? 1 \(\sum \) Yes 2 \(\begin{align*} 2 \text{No} \)	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pregn Other (specif)					Month	Day Year
P.O.	that the ed by th detache	hys	9 Unknow	9□ Unknown									
- 0	w requires that s been signed E should be deta	by	Part II. Other significant condi	tions contributing to death	but not resu	Iting in the u	M/C	e given in Pari	til.		bacco us es 2□		ne cause of death?
250 8	law re as bee 2 sho	piet	V	V	4	/				24a. Was a		24b. Were auto	psy findings available
12. R	The lav	Completed								autop: perfor	med? 2 XI No	death?	impletion of cause of
9-32-830 Vital Record	ilcien: Th certificate rector, pag	0	25. Was case referred to medic	cal				26. Plac	ce of Deatl	(Check only or	/	1 103	20110
	Physicien: this certific al director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpati	ent 2 🗆 E	EP/Outpatien	t 3 DOA	Other: 4   N	Nursing Ho	me 5 🗌 Resid	ence 6	Other (Specify	y)
700	ding Pr		27. Manner of Teat 1 1 Natural 5 ☐ Pend	28a. Date of Inj	ury ay Year)	28b. Time of	28c.	Injury at Work?		28d. Describe h	ow injury	occurred	
N N	Attending r death. actor: After	atic	Accident inves	stigation		,,		1 Yes 2	]No				
Sydney	or Att	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	mined 286. Place of In	ijury - At hor tc. (Specify	me, farm, str	eet, factory, off	fice		28f. Location (S City or Tow	treet and n, State)	Number or Rura	l Route Number,
Koziel, Sydney Division			00 0 00										
Zig	Hospital	edical	(Check only Z Medic	ring Physician: To the best of Examiner: On the basis	of examinati	vledge, death on and/or inv	occurred at the restigation, in r	he time, date a my opinion, de	and place, eath occurr	and due to the c ed at the time, c	ause(s) a late and p	nd manner as si place, and due to	tated. the cause(s)
3	thin S	Mec	one) 29b. Signature and the of certification	and hanner s	tated.		29c. Lie	cense number	,		9d Date	signed/Month,	Day Year)
	on Son			1. 1/16	Ξ.	Δ	n.	1115	25	2	81	8/10/	
	~ De		20 Name and address of an	man completed	er U	220) /	Print)	11-30	0		DI	000	0
/,	180		30. Name and address of person	who completed cause of	death (Item	LJaj (1900,	Palthi	1. Kill 1	Drive	150-1	in	my.	1811
	Sta	te	31. Date filed (Month, Day, Yes	ar) 32. <b>Pa</b> gist	rar's Signat	ure 17	e of the	~ (	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1/0			
	Registr		AUG 1	1 2006 Bene	NO A	15 A	melle						

			For State Registrar		State	of Maryla		artment of rtificate of	Health and M	Mental H	lygier Reg. 1		16	27012
	Physici	an	1. Decedent's Name							2. Date of Month		2006	Year	3. Time of Death
	/Medic	al	Thomas  4a. Facility Name (#		illy, S			4h Cihi Tour	or Location of Death			4c. County of		9:56ам
	Examin	er			. •	u <i>mber)</i>		, ,	apeake C		,	c. County o		
	Funeral		209 Gr 5. Social Security N		6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Yea	r If Under 24 Hrs.		Birth		9. Birthp	place (State or Foreign
	Director		220-24-8	165	1 <b>⊠</b> M 2□ F	7	6 Yrs.	Months Day	s Hours Min.	8. Date of (Month, August	IO, I	929	Couir	WV
	D .		Usual Residence of 10a. State	Decedent 10b, County		100	City, Town or Lo	· · · · · · · · · · · · · · · · · · ·						0d. Inside City Limits
	laryla shov	ř	MD	Cec	i 1	100.	•	peake (	7i+v				'	1 € Yes 2 No
	death with the Maryland ms 23a or 28a-f show Livest Lettellford at	Funeral Director	10e. Street and Nun		++		Circoa	10f. Zip Code	<del>_</del>		10a. (	Citizen of W	hat Cour	ntry?
	3a or	٥	209 Gr		Ave.				1915			U.S.		,
	death	nera	11. Marital Status	7		cedent Ever in	1 U.S. 13.		Hispanic Origin? (Suban, Mexican, Puerto	pecify Yes or	No-			can Indian,
9	after or its		1 Never Marri		ied 1 □XYes	2 No -		1 ☐ Yes 2 ☐XN		Frican, etc.)		Specify:	i, White, <b>Wh</b>	ite
Š	72 hours after death with the Marylan 72 hours after death with the Marylan "natural", or hams 28a or 28a-1 show cifed Everili at real termolified at	d by	3 Widowed		Year or	Dates:					401			
7.	in 72 in 72	ojete		ify only highe	t's Education st grade completed		(Give	dent's Usual Occ kind of work don DO NOT use reti	e during most of won	king	160.	Kind of Bus	iness/in	dustry
75	s within piene. r then	Completed	Elementary/Secon	ndary (0-12)	College	(1-4or 5+)	Au	to Mecl	nanic			Aut	omo	tive
5	e filec al Hyg l otha vant,	3e C	17. Father's Name (	First, Middle,	Last)				18. Mother's Nam	ne (First, Mide	dle, Maid	en Sumame	)	
Z I	ould b Menta arked	To Be	John Li	11y						McBr				
Maryland 21215-0036	2 short and is m		19a. Informant's Na			/0			et and Number or Ru					
	1 and 1 and Health em 27 thar t	1	Thomas 20a. Method of Disc		IIY, Jr.		p. Place of Dispo	sition (Name of	Corner	Ra.,	-	Location - (		
jo	ages int of t: if it			Cremation	3 Removal from		cemetery, crei	matory or other p	May	10,20			,	ster,PA
Baltimore	permit. Pages 1 and 2 should be filed within 7 bepartment of Health and Mental Hygiene important: if I tem 27 is marked other than "any injury or other traumatic event, the Median 2008.		21. Signature of Fu					2. Name and Add						
ű			<b>&gt;</b>	HIL					G. Gee F				210	2.1
			23a. Part1. Enter to shock, or hear	ne disease, or it failure. List	complications that	caused the de	eath. Do not en	ter the mode of d	MainSt., ying, such as cardiac	or respirator	arrest,	MD	219	Approximate Internal Balwelli On et and Death
	Physician		Immediate Cause (	Final n	C	OP	$\mathcal{D}$							Veq (S
W	/Medical Examiner		resulting in death)		Due t	o (or as a cons	sequence of):							1
5		-	Sequentially list con	nditions,	b. Due t	o (or as a cons	sequence of):	79						
d	uted d ansit	Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events	rlying injury	<b>(</b>	(	~							
$\mathcal{D}_{i}$	be executed ician and burial-transit	Еха	resulting in death) L		Due t	o (or as a cons	sequence of):							
8760	ste ste	dicai			d									
<u> </u>	leath certifica attending ph	Med	IF FEMALE:											
S S S S S S S S S S S S S S S S S S S	that the death cer ed by the attendir detached for use	Physician/Me	23b. Was decedent in the past 12	months?	1 Live	outcome of pre- birth 2 F gnant at time of	etal death 3	Ectopic pregnar Other (specify)	ісу			23d. Date Mon		ery Day Year
5 0	the de	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	9 Uni		or death 3L	J Other (specify)						
څ څ	requires that the	by Ph	Part II. Other signif	icant condition	ons contributing to	death but not	resulting in the u	nderlying cause	given in Part I.	23e. Di	d tobacc	o use contri	bute to th	ne cause of death?
	w requires been sign	ed b	<u> </u>	N						Ď	Yes	2 □ No 3	3 🗌 Prob	pably 4 □Unknown
- S	e law re has bee	plet	$\mathcal{Q}$	Mt	2_					24a. W	as an itopsy	24b. W	ere auto	psy findings available
Vital Becords.	The law ate has be page 2 s	Completed								pe 1 Tyes	rformed'	2 de	eath?	mpletion of cause of
ا jta	Physician: The this certificate ral director, pag	Be	25. Was case referr	red to medical				T	26. Place of Dea	th (Check on	lv опе)			
of (	this aldi	2	1 Yes 2	No			ER/Outpatier	11 3L DOA	ther: 4 Nursing H					y)
u	fte ng	tion	27. Manner of Death Natural	5 Pendin		e of Injury onth, Day Year	28b. Time o Injury	, W	ork? ☐ Yes 2 ☐ No	28d. Describ	e now in	jury occurre	a	
Division	Attanding in death. actor: After by the fune	fica	2 Accident 3 Suicide	6 Could	not be	ce of Injury - A	it home, farm, sti	reet, factory, offic		28f. Location	n (Street	and Numbe	r or Rura	I Route Number,
Ö	s after	Certification:	4  Homicide	= 2150	bui	ding, etc. (Spe	ecify)			City or	Tòwn, Sta	ate)		
	To the Hospital or Attandii within 24 hours after death. To the Funaral Director: A completely filled in by the fu		29a. Certifier (Check only	1 Certifyin	ig Physician: To t	he best of my			time, date and place,					
	the H hin 24 the F nplete	Medical	one)		and ma	inner stated.		- Jonganon, III III)	Spiritori, deglir decu		201	Data -!-	/4/0016	Day Ves-1
	vit To con	-	29b. Signature and	title of certifie	/1	e for a		29c. Lice	nse number		29 <b>d</b> . [	zate signed	(Month,	-04
		1	ne	na V	Jem	avs	h 00:1	77%	1 3 103	<u> </u>			10	00
Ē	STIVA	l ii	50. Name and address	. /	who completed a S & M /	use of death (I	Item 23a) (Type,	1C 1	nse number  5105  erry Pori	n + 1	MI	) 2	191	00
Ĭ	Sta	ite	31. Date filed (Mon			legistrar's Si	gnature	and a	/ / / / / /	., ,				
	Registr	ar	14	HI TO	2000	Alle S	N. 14	Alleran						

State of Maryland / Department of Health and Mental Hygiene 🤈 [ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** William Μ. Lambert 5:24P 2006 Aug. /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Prince George District Heights 2002 Brewton St. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F 86 Months Days Hours 577-12-6234 29,1920 Wash.D.C Director Jan. Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County rthan "natural", or Itams 23a or 28a-f ahow the Medical Exercises must be notified at 1 XYes 2 No Maryland Prince George District Heights Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2002 Brewton St. 20747 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Status Black, White, etc s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or ite 1 Never Married 2 Married or l White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ð 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation e kind of work done during most of working DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Enviormental Technician Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Α. Lambert Catherine M. Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Susan M. Renna/Daughter 8214 Hillcrest Rd. Annandale, VA. 22003 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages
Department of Important: If It
any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Md. Veterans Cem. 8/11/06 Cheltenham, MD. 22. Name and Address of Facility Geo. P. Kalas Funeral Home 21. Signature of Funeral Service Licenses 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 2 % 23a Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final Acute Cardio-Respiratory Failure **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Anemia of Vitamin B12 Deficency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Coronary Artery Disease burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Pacemaker Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months?
1 Yes 2 No ģ 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 XNo 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 XYes 2 □ No 2 ER/Outpatient Certification: To 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0009179 8/8/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ata Moshyedi, M.D. 7305 Hanover Parkway A Greenbelt, Md. 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar 1 2006

**ORIGINAL** 

		For State	State of Marylan		nt of Health an	nd Menta		L UU	2701
		Registrar  1. Decedent's Name (First, Middle, Last,			ile or beatir		Reg. No of Death		3. Time of Death
Physici /Medic		MILDRED	LONG			AU		7 2006	2134 M
Examin	-	4a. Facility Name (If not institution, give		4b. Cit	y, Town, or Location of D	Death	4	c. County of Deatl	
			unty Gene	Ral Hospi	a Co	lumb	1a	Howa	Rd
Funeral		5. Social Security Number 6. Sec	M 2017. Age (In yrs.	Month	er 1 Year If Under 24 s Days Hours	Min. 8. Dat	e of Birth onth, Pay, Yea	9. Birth	nplace (State or Foreign
Director		Usual Residence of Decedent		0		770	61141	700 50U	th Carolina
aryland show		10a. State 10b. County		y, Town or Location					10d. Inside City Limits
e Mar re-f sl	ctor	Maryland Howard	1 (	Columbi	å				1 Yes 2 No
or 28e-f	Director	10e. Street and Number	DIA	10f. 2	Zip Code		10g. 0	Citizen of What Co	untry?
s 23a	rai	7260-1 Edei	1 Grook D	RIVE	edent of Hispanic Origin	2 /52/ 0		Luited 14. Race - Amer	States
items	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 N No	If Yes, sp	pecify Cuban, Mexican, F	Puerto Rican,	etc.)	Black, White	
urs af	by	3 ☐ Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 □ Yes	2 No Specify:			Specify: Bla	ack
s 1 and 2 should be filed within 72 hours after death with the Maryland fleelf and Mental Hygiene.  Theelful and Mental Hygiene.  The fleelful and Mental Hygiene.  Other traumatic event, the Medical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Decedent's Us	sual Occupation work done during most of	f working	16b.	Kind of Business/l	ndustry
Athin ne	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired)		٨	1 . 10	. 1
iled w Hygier ther ti		17. Father's Name (First, Middle, Last)		Nurse		Name (First	Middle, Maide	an Sumame)	۱.
d be f antal h	Be c	Tours	2.5		0		T	A 0 C	
2 should be filed within and Mental Hygiene. Ie marked other than aumatic event, the Manaultic event, the Manaulti	2	19a. Informant's Name/Relationship (Ty		19b. Mailing Addre	ss (Street and Number of	or Rus Route	Number, City	or Town, State, Z	ip Code)
and 2 eelth a m 27 ie		Javice Moto	M	7260-F	Eden Br	ook b	B. C.	olumbia.	Md 21046
item item of Hee		20a. Method of Disposition		Place of Disposition (A	lame of	Date	20c.	Location - City or	own, State
Pages ment of I ant: if its ury or o		1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	A bunlyan	lational A	19.11,2	006 L	aurel,	Md.
permit. Pages 1 and 2 Department of Heelth a important: If Item 27 is eny injury or other tra gncs.		21. Signature of Funeral Service Cicens		22. Name	and Address of Facility	POP	e.P.A		
4 90 E 9 9		with de / Sur	5411085	5538	narlboro Pi			He, md.	20747 Approximate
		23a. Part i. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.	. //	/	rdiac or respi	ratory arrest,		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	. Intracran		9				
Examiner			Due to for as a conseq Cerebral	ane 4m	icm				
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq						
cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	÷						
e exe	Ex	resulting in death) Last	Due to (or as a conseq	juence of):					
cate be executed physicien and the burial-transit	dicai		i						
certifi ding r	/Me	IF FEMALE:	3c. If yes, outcome of pregna	ancv				23d. Date of deli	very.
etten	cian	in the past 12 months?	1 Live birth 2 Fete 4 Pregnant at time of d	el death 3 □Ectopic				Month	Day Year
the d	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		. , ,				
s that	by P	Part II. Other significant conditions con	ntributing to death but not res	sulting in the underlying	g cause given in Part I.	23	e. Did tobacci	o use contribute to	the cause of death?
equire en sig	ted	Kenal Cadaver	ic Transpla	nt		_	1 🗌 Yes	2 □ No 3 □ Pro	obably 4 Unknown
law ras be	Completed	Hypertension				24	a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
: The	Con	Atrial tibr	illation			10	performed? Yes 2		2□ No
ician certifi rector	Be	25. Was case referred to medical examiner?	lospital:		Other	f Death (Chec			
P P P P P P P P P P P P P P P P P P P	: To	1 Yes 2 No	1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of	28c. Injury at Work?		Residence escribe how in	6 ☐Other (Specially occurred)	ufy)
nding tth: :: Afte	Certification;	1 ☑ Accident 5 ☐ Pending investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No				
Attended Sector by the	tifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, fact	ory, office	28f. Lo	cation (Street y or Town, Sta	and Number or Ru	ral Route Number,
itaio ris aft rai Dir ted in	Cer								
Hosp 4 hou Funei ely fii	cai	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina	owledge, death occurre ation and/or investigati	ed at the time, date and poor, in my opinion, death	place, and du occurred at th	e to the cause ne time, date a	(s) and manner as and place, and due	stated. to the cause(s)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	one)  29b. Signature and title of certifier	and manner stated.		29c. License number			Date signed (Month	
F 3 F 8		152	mo			62			
$\rho(2)$		30. Name and address of person who co	impleted cause of death (Iter		DOO 436	,,		11009 /	ZUV.
ro		WILLIAM BO	11		y General	Hospi	tal 1	(olumbic	mo
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature d	/				

State Registrar

AUG 1 1 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 920 **Physician** CLUGUST James Robert Lockard 07 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Geroge's Doctors Community Hospital Lanham 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 ☐ F Months Days Hours Min 711-07-6900 84 Yrs. 7/27/1922 Pennsylvania Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ahow or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No New Carrollton Maryland Prince George's Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20784 5807 84th Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 1 Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or items 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: þ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, Ite Marico once. e kind of work done during most of working DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Meehan Joseph Lockard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5807 84th Ave., New Carrollton, MD Ruth E. Lockard - Wife 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a Method of Disposition 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 9/1/06 Arlington Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalore J Fyrieraf Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 arrent 11111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** DYSRHYTHMIA minores /Medical Due to (or as a consequence of) Examiner ARTGRY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 🗌 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ٤ this ieral Director: After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 1 ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD 54675 8/8/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 575 PLAN STREET SUITE 351 LAUREL MID JU SHOBHIT 31. Date filed (Month, Day, Year) State AUG 1 1 2006 Registrar

Box 68760.

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Division of Vital Records.

		1 - State Ragistrar		artment of Health and rtificate of Death	Rag.	No	70
Physici /Medic	al	1. Decedent's Name (First, Middle, Last)  Adele McMaster Lindahl			August	8 2006	ime of Dea 9:00
Examin Funeral Director	ier	4a. Facility Name (If not institution, give street and number)  8105 Oakwood Dr.  5. Social Security Number  043-01-2030  7. Age	(In yrs. last birthday) 91 Yrs.	4b. City, Town, or Location of Dea Clinton  If Under 1 Year If Under 24 Hrs Months Days Hours Min	8. Date of Birth	4c. County of Death  Prince <u>Georg</u> 9. Birthplace ( Country)  1914 Norwicl	State or Fo
	tor	Usual Residence of Decedent  10a. State 10b. County  Md Prince George's	10c. City, Town or Lo	cation		10d. Ins	side City L
e or 28a- be notif	Direct	10e. Street and Number		10f. Zip Code 20735	10g.	Citizen of What Country?	
"neturel", or items 23e or 28e-f show olds! Examiner must be notified #1	Completed by Funeral Director	8105 Oakwood Dr.  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  1 12. Was Decedent E Amed Forces? 1 Yes, Give Year or Dates:	0	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puei 1 ☐ Yes 2 ☒ No Specify:	Specify Yes or No- to Rican, etc.)	USA  14. Race - American Inc Black, White, etc.  Specify: White	fian,
e. an "neture Medical E	npleted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	nrking 16b	Kind of Business/Industry	
Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netum any injury or other treumatic event. It a Madical once.	To Be Con	12 3 17. Father's Name (First, Middle, Last) Elias Joseph Courey	Ac		me (First, Middle, Maid Massad	S Government	
Ith and M 27 is mar r treumat	-	19a. Informant's Name/Relationship (Type, Print)  H. Joseph McMaster/Son		ng Address (Street and Number or R Oakwood Dr. Clin		y or Town, State, Zip Code, 0735	)
Department of Health amportent; if item 27 is any injury or other treasons.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)	Arlington		25/06 Ar	Location - City or Town, Si lington, VA	tate
Department Importent: I eny injury o		21. Signature of Funeral Service Licensee  Musph for Judian for 23a. Parts. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each lin	the death. Do not ent	2. Name and Address of Facility Murphy FH 4510 W Arlington, er the mede of dying, such as cardia	VA 22203	Appro	oximate val Betwe
ysician hysician and hysician and hysician the prival-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events c.	a consequence of):	lial Infarc Kidney Fa	fich	18	Men Pond
ed by the attending phys detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day	Yea
5 g	ا ۾	Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlyi <i>n</i> g cause given in Part I.	23e. Did tobacc	o use contribute to the cause 2 No 3 Probably	
cate has been si page 2 should	Completed				24a. Was an autopsy performed		on of caus
certifi	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		Othor	ath (Check only one)		
within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	atlon; To	27. Manner of Death  1 X Natural  2 Dending  1 Dending  2 Accident  28a. Date of Injur  (Month, Day)	y 28b. Time o	it 3 DOA 4 Nuising i	Home 5X Residence 28d. Describe how in		
irs after de ral Directo led in by tl	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju	ry - At home, farm, str . (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route ate)	e Numbe
within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier  (Check only one)  1 ☑ Certifying Physician: To the best of 2 ☐ Medical Examiner: On the basis of and ma/ner sta	examination and/or in	vestigation, in my opinion, death occ	urred at the time, date a	and place, and due to the ca	
Tot	2	29b. Signature and title of certifier		Olola303	_	S 10 06	'ear)
(4)		30. Name and address of person who completed cause of de Tohn k. Kim 6300 St	eath (Item 23a) (Type,		A		2304

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene
	_	For State of Wallytand / Department of Health and Wental Hygiene   1 - State Registrar   Certificate of Death   Reg. No.
Physicia	ın	1. Decedent's Name (First, Middle, Last)  Nancy Ann Robbins Lewis  2. Date of Death  Month  Pay  Year  7  2. Obs  M
/Medica		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death
		DORCHESTER GENERAL HOSATAL CAMBRIDGE DORCHESTER  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
Funeral Director		5. Social Security Number 219–36–6820  6. Sex 1 Months Days Hours Min. Days Hours Min. Days Hours Min. Dec. 9. Birthplace (State or Foreign Months) Page 1939  9. Birthplace (State or Foreign Months) Days Hours Min. Dec. 1939  9. Birthplace (State or Foreign Months) Days Hours Min. Dec. 1939  9. Birthplace (State or Foreign Months) Days Hours Min. Dec. 1939  9. Birthplace (State or Foreign Months) Days Hours Min. Dec. 1939  10 Months Days Hours Min. Dec. 1939  11 Months Days Hours Min. Dec. 1939  12 Months Days Hours Min. Dec. 1939  13 Months Days Hours Min. Dec. 1939  14 Months Days Hours Min. Dec. 1939  15 Months Days Hours Min. Dec. 1939  16 Months Days Hours Min. Dec. 1939  17 Months Days Hours Min. Dec. 1939  18 Months Days Hours Min. Dec. 1939  18 Months Days Hours Min. Dec. 1939  18 Months Days Hours Min. Dec. 1939  19 Months Days Hours Min. Dec. 1939  20 Months Days Hours Min. Dec. 1939  20 Months Days Hours Min. De
and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limits
Maryli Maryli	ţō	Maryland Dorchester Cambridge 1 □ Yes 2 □ No
or 28s	Direc	10e. Street and Number  10f. Zip Code 10g. Citizen of What Country? 208 Meteor Ave. Apt. 503 USA
eath w	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
6 after d	Fun	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No   If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  White, etc.  White, etc.
246-0036 thin 72 hours aff e. an 'natural', or Medical Exercise	ed by	3 Wildowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
248 hin 72 in na	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use mitted)
1213 led will har the		12 8 Teacher Education
aryland 2 should be filt	To Be	17. Father's Name (First, Middle, Last)  Baker Robbins  18. Mother's Name (First, Middle, Maiden Sumame)  Betty Bell
S should and M and M is mark	-	19a. Informant's Name/Relationship (Type, Produghter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
e, M		Camilla Baker Robbins Lewis 414 Glenburn Ave., Cambridge, MD 21613  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  Date 20c. Location - City or Town, State
MOT mor		1
Baltimore, Maryland 21248-0036 Period Maryland 21248-0036 Permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-1 show any injury or other traumatic event, it a Medical Evarination in the notified at once.		Name and Address of Facility  Name and Address of Facility  Mid Shore Cremation Center, P.O. Box 1464,  2272 Hudson Rd., Cambridge, MD 21613
		23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)  Onset and Death  Onset and Death
/Medical Examiner		Due to (or as a consequence of):  Evolocity (MRSA)
P 15	iner	Sequentially list conditions,  The place of
760, se executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last  C. Due to (or as a to sequence of):
be be burner	ā	d
Box 687 eath certificate attending phys for use as the	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
. 7 . 7	Physician/Medic	23b. Was decedent pregnant in the past 12 months?  1
	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Denknown
4) @ 20	Completed	24a. Was an autopsy findings available prior to completion of cause of death?  1 9 9 2 10 70 1 9 9 2 10 70
ital	BeC	25. Was case referred to medical 26. Place of Death (Check only one)
of V Physic this ce	၉	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
ion nding ath. r: After e funer	ation	27. Manner of Death  1 Product
Divis	Certification;	3 Suicide 6 Could not be determined 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State)
Division of Vital Re To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  1
To tr within To tr comp	Ž	29b. Signature and title of certifier  D-63366  29d. Date signed (Month, Dey, Year)
		30. Name and address of person who completed cause of death (Item 23a) Type, Print) Dovetheste Gen. Hospital
Sta Registr		31. Date filed (Month, Day, Year) AUG 1 1 2006  32. Segistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

AUGUST

0		$\cap$		0
1	1	U	1	U

3. Time of Death

4:26 A M

2006

4c. County of Death

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

MARY MARIE LEWIS

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or iteme 23a or 28a-1 show eny injury or other traumatic event, the Madical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	FORT WASHINGTON HOSPITAL		FORT WASH	IINGTON	F	PRINCE GE	EORGES
	1 M 2 T€F	(In yrs. last birthday) 86 Yrs.		Hours Min. 8. DE	Date of Birth Month, Day, Year, CEMBER 18,	9. Birth	place (State or Fore ntry) YLAND
or	Usual Residence of Decedent  10a. State 10b. County  MARYLAND PRINCE GEORGES	10c. City, Town or Lo					10d. Inside City Lim
Director	10e. Street and Number 719 MANNING ROAD EAST	HOOOKIIIK	10f. Zip Code 20607	···	1	tizen of What Cou	ntry?
Funeral	11. Marital Status  12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hisp	panic Origin? (Specify Mexican, Puerto Rica	Yes or No-	14. Race - Ameri Black, White,	can Indian,
by Fu	1 Married 2 Married 1 Yes 2 Married 1 Yes 2 Married 1 Yes 2 Married 1 Yes Give Year or Dates:	0	v	Specify:	,, ((),	Consider	ACK
Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupati kind of work done du DO NOT use retired)	on ring most of working	16b. K	(ind of Business/Ir	ndustry
Com	Elementary/Secondary (0-12)  2 YEARS  17. Father's Name (First, Middle, Last)	LICEN	ISED PRACT	CAL NURSE  8. Mother's Name (First		ERAL GOV	ERNMENT
To Be Completed by Funeral Director	HENRY LEWIS			ESTELLE BLA			
	19a. Informant's Name/Relationship (Type, Print) PHYLLIS BOWMAN / GREAT NIEC			d Number or Rural Roll  JE, INDIAN			20640
	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State	20b. Place of Dispo		Date		ocation - City or T	
	4 Donation 5 Other (Specify)  21. Signature of Funeral Service Service Signature of Funeral Service Serv	22	2. Name and Address	TERY 8/16/2		OKEEK, M	ARYLAND
	ANDIA C. THORNION JOHNSON MOO	Trace	HORNTON FLINE	RAL HOME, P.A. ON ROAD, INDI	AN HEAD, M	MARYLAND 2	0640
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events c.	consequence of):  consequence of):  consequence of):		rdis Van L			9
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2₺No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv	ery Day Year
by Ph	Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cause given	in Part I.			he cause of death?
leted					1∐ Yes 2 24a. Wasan		bably 4 QÛnkno
Complete					autopsy performed? I ☐ Yes 22 No	prior to co death?	mpletion of cause
Be	25. Was case referred to medical examiner?  Hospital: Hospital:		Other	26. Place of Death (Ch			
atlon: To	1  Yes 2 No	28b. Time of	f 28c. Injury a Work?	t 28d.	5 ∐ Hesidence Describe how inju		(fy)
Certification:	a Could not be	ry - At home, farm, str. (Specify)	reet, factory, office	28f. L	ocation (Street an City or Town, State	nd Number or Run e)	al Route Number,
edical	29a. Certifier (Check only one)  Cartifying Physician: To the best of and manner state	examination and/or in	h occurred at the time, vestigation, in my opin	, date and place, and d nion, death occurred at	due to the cause(s the time, date an	) and manner as s d place, and due t	stated. o the cause(s)
Me	29b. Signature and title of certifier  M.O.		29c. License r	51/6		tte signed (Month,	2006
	30. Name and address of person who completed cause of de	ath (Item 23a) (Type,	ng Sta Rd	H (01 +	est wa	Hlista	M0207
ate rar	31. Date filed (Month, Day, Year)  0 8-1/-226  32. Registra	r's Signature G 1 4 2006	Been.	1. Sparle	,		

			For State Registrar	State of Mai	-	epartmen Certificat			d Mental H	ygiene Reg. No	4000	27019
	Physici /Medi		1. Decedent's Name (First, Middle, Last)  Melvin Leat	herbur	4				2. Date of D Month	. 8º	2006	3. Time of Death /3/6 M
	Examir Funeral	ner	4a. Eacility Name (If not institution, give str Peninsula Regional 5. Social Security Number 6. Sex	Medical 7. Age	Center (In yrs. last birtho	5	clist	Location of D DUUY If Under 24 Hours	Hrs. 8. Date of E		County of Death  Wicomic  9. Birthp  Cour	lace (State or Foreign
	Director		219 - 82 - 9/49  Usual Residence of Decedent  10a. State 10b. County	W 2□F	43 Yrs	š.	Days	Hours	Sept		162 Mar	7
6/14	r 28a-f ehow	Irector	Maryland Wicomi	20	Salish	10f. Zip				10g. C	tizen of What Cour	1 Yes 2 □ No
9-82-8	I'E, IMATYIANG Z I Z I 3-UU30 s 1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hyglene. Item 27 is marked other then "natural", or items 23s or 28s-1 ehow then treumatic event, the Medical Exartinar must be could a set to the treumatic event.	by Funeral Director	1 Never Married 2 Married	2. Was Decedent Ev Armed Forces? 1 Myes 2 No	ver in U.S.		2. 1		? (Specify Yes or I everto Rican, etc.)	Unit	14. Race - Americ Black, White, Specify: TS	ean Indian, etc.
my 219	Maryland Z IZ I 5-0030 nd 2 should be filed within 72 hours after tith and Mental Hygiene. 27 is marked other then "natural", or lite r treumatic event, the Medical Exercita-	Completed by	3 Widowed 4 □ Divorced  15. Decedent's Educt (Specify only highest grade)  Elementary/Secondary (0-12)	Year or Dates:	(C	ecedent's Usua Give kind of wo fe. DO NOT us	al Occupa rk done d se retired,	ation furing most of	working	16b. F	(ind of Business/In	dustry
leathenbur	laryland 212 2 should be filed within and Menta Hygiene. Is marked other then eumatic event, tra M	To Be Cor	17. Father's Name (First, Middle, Last)  Lercy O	Leathe	rbury,	Sr.	ore		Name (First, Midd	le, Maidei	n Sumame)	ırd
Leath	ore, Mary		19a. Informant's Name/Relationship (Type Corey Haywan		19b. M	Je	iseu	Rd ,	De Rural Route Num	и,		1801
Melvin	Page nent o ant: If ury or		20a. Method of disposition  1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)  21. Signature Funeral Service Licensee		Spring	crematory or c	ther place (em0	ng Qu	4 12,200k	1.4	ocation - City or To	
Me	Dalt permit. Departr Imports eny Inji		23a. Party Enter the disease, or complic	Mary ations that caused t	he death. Do no	Ward	Han	unera 1den	Aue Fridac or respiratory		ss Anne,	MO Approximate
	below.  by sicien and physicien and site burial-transit site burial-transit	dical Examiner	shopk, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that intitated events resulting in death) Last  d.	Due to (or as a	consequence of)	:	lo m	ndo sa	vecmer			Interval Between Onset and Death
1	VISION OT VITAL RECORDS, P.O. BOX 68/ Attending Physicien: The law requires that the death certificate has been signed by the attending physicity the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death	3 □Ectopic p 5 □ Other (sp				-	23d. Date of delive	ery Day Year
	Kords, P.  Wrequires that I been signed by should be deta	þ	Part II. Dther significant conditions cont	nibuting to death but	not resulting in the	ne underlying o	ause give	en in Part I.	iii ii		use contribute to to	
!	LIVISION OF VITAL HECOTOS, I or Attending Physicien: The law requires th after death. Director: After this certificate has been signe d in y the funeral director, page 2 should be	Completed							pe 1 ☐ Yes	topsy rformed? 250 N	prior to co death?	opsy findings available mpletion of cause of
	r VITA ysicien: is certific director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	t 2 ER/Outp	atient 3□ D0	Cthe	05	Death (Check onl		6 □Other (Specif	
	Ntending Phy death. ctor: After this y the funeral d		27. Manner of Death 11 Neteral 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day			28c. Injun Wor		28d. Describ			7)
i	DIVIS  To the Hospital or Atte within 24 hours atler de To the Funeral Directo completely filled in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injurbuilding, etc.	(Specify)				City or 1	Town, Sta		
	Hosp 24 hou Fune etely fil	edical	29a. Certifier (Check only one)  2 Medical Examination	er: On the basis of and manner state	examination and/	death secured or investigation	at the tin	na data and p pinion, death	stane, and due to the occurred at the time	e, date ar	i) and manner as and place, and due to	o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	20		29	Λ	2050		29d. D	ate signed (Month,	Day, Year)
	N.X		30. Name and a down of who cor		ath (Item 23a) (T	ype, Print)	10				anny	m
	St Regist	ate rar	31. Date filed (Month, Day, Year)  AUG 1 1 20	7 7 5 0 32. Registra	r's Signature	Anarle	NKK	. 600	1 1 7	VISI	H N My	II W

			1 - For State Registrar	State of M	-	partment of H		nd Mental Hy	giene 200	6 27020
			Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath	3. Time of Death
	Physici		Ethel Marie M	Morris				August	8 200e	12:45 PM
	/Medic		4a. Facility Name (If not institution, giv		1	4b. City, Town, or	r Location of		4c. County of D	
	Examin	er	Crofton Convales			Crof			Anne A	
-			5. Social Security Number 6. S		ge (In yrs. last birthda		If Under 2	4 Hrs. 8 Date of Birt		Birthplace (State or Foreign
	Funeral Director			_M 2☐¥F	86 Yrs.	Months Days	Hours	Min. 8. Date of Birth (Month, Day OCt. 3	, 1919 Wa	country) aterloo, Iowa
			Usual Residence of Decedent		00			1000. 3	, 1919 110	icerico, iowa
	land		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary	ō	MD Anne Ara	ındel	Crofto	on				1 DXYes 2 □ No
	the 28a	ec C	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	with se or	<u> </u>	1716 Gunwood Pla	CO			114		USA	,
	eath	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13			in? (Specify Yes or No-		merican Indian,
	lter d	ä	1 ☐ Never Married 2 ☐ Married	Armed Forces' 1 ☐ Yes 2 🔀		If Yes, specify Cuba	n, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	Black, W	hite, etc.
36	rs af	by F	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify:	White
21215-0036	72 hours after death with the Maryland "neturel", or Items 23e or 28e-f ehow idical Examiner must be notified at	ed	15. Decedent's E		16a. Dec	edent's Usual Occup	ation		16b. Kind of Busine	
15		Completed	(Specify only highest gra	ide completed)	(Gir	re kind of work done of DO NOT use retired	during most (	of working		
12	d within plene. r than "	E	Elementary/Secondary (0-12)	College (1-4or	5+)	Homemaker			Own hor	ne
9	E T E T	Ö	17. Father's Name (First, Middle, Last	)			18. Mother	's Name (First, Middle,		
an		To B	George Herbert	Spaulding			Haze	el Bruce		
2	should and Men ie marke sumatic	F	19a. Informant's Name/Relationship (		19b. Ma	iling Address (Street		or Rural Route Numbe	r. City or Town, Stat	e. Zip Code)
Maryland	d 2 tra		Rebecca Benjamin	/ daughte		Gunwood :		Crofton,	•	
ē	s 1 an f Heal item 2 other		20a. Method of Disposition	,		position (Name of ematory or other place	-	Date	20c. Location - City	
2	m O		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special					8/09/2006	Meyandr	i ο 1/7
Baltimore,	ift. Partme		21. Signature of Funeral Service Licer	_	pecropor.	22. Name and Addres				la, VA.
Ba	permit. Page Department of Important: if eny injury or once.		PR	2.0	0	6512 NW C		Beall Fun		20715
	-		23a. Part1. Enter the disease, or com	plications that cause	d the death. Do not e					Approximate
н			shock, or heart failure. List only	one cause on each I	ine.		9, 000. 00	arada ar roopiiatory ar		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Der	nentia					443
	Examiner		1	Due to (or as	a consequence of):	0,0				
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	ed sit	Jue	cause. Enter Underlying Cause (Disease or injury	60 5 1 6	2	2146				110
_	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	7/1/1/3	_		_	72
8760,	be e ician buria	calE		•	. ,					
87	phys the			_ d						
9 x	ding ding se as	₩e	IF FEMALE:	23c. If yes, outcome	of programmy					
Вох	eath certific attending pl	an	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	☐Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
	The law requires thet the death centificate be executed sie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregnant a 9⊟ Unknown	t time of death	□ Other (specify)				
P.0	thet ti		Part II. Other significant conditions of	contributing to death l	but not resulting in the	underlying cause give	en in Part I	23e. Did to	obacco use contribut	e to the cause of death?
S,	signe signe d be	þ	, <b>.</b>		<b>.</b>	and anything databas give	O	1 🗆 Y	_/	Probably 4 Dunknown
5	w requir been si should	etec								
Vital Records,	e 2 s	Completed						24a. Was	an 24b. Were prior	autopsy findings available to completion of cause of 1?
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/its	ician: certific rector,	Be	25. Was case referred to medical examiner?	11		lou	-	of Death Check only o	ne)	/ \
of	Physic this c	မ	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati			4 Murs	sing Home 5 Resid		(pecify)
_	ng f fter ner	ü	27. Manner of Death 1 Anatural 5 Pending	28a. Date of Inj (Month, Da	ury 28b. Time ay Year) lnjury	Worl			now injury occurred	
sio	ttending F death. ctor: After / the funer	cati	2 ☐ Accident investigatio				Yes 2□N			
Division	of or Attended of the desired of the chartest of the chartest of the desired of t	Certification:	3 Suicide 6 Could not be determined	289. Place of in	jury - At home, farm, tc. (Specify)	street, factory, office		28f. Location (5 City or Tow	Street and Number of yn, State)	Rural Route Number,
	urs el urs el urs el urs el							ļ		
	To the Hospital or Atti within 24 hours efter de To the Funeral Direct completely filled in by ti	Medical	29a. Certifier Certifying Pl	niner: On the basis	of examination and/or	ath occurred at the tin investigation, in my o	ne, date and pinion, death	place, and due to the o noccurred at the time, o	cause(s) and manne date and place, and	as stated. due to the cause(s)
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0	(6)		30. Name and address of person who				<b>#222</b>		0071-	
			Rakesh Arora, M 31. Date filed (Month, Day, Year)		Gallant I	ox Lane	#222	Bowie, MD	. 20715	
	Sta Registi		AUG 1 0 2008	Real .	A Spe	les .				
DH	MH 17 Rev 1/2		MOU 1 0 5000		- //-					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2006 AUGÜST Physician 3:36 PM 11. Lawrence Beall Munshaur /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Feb 25 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** <sup>Year)</sup> 1928 **№** M 2□F MD 78 216-28-8223 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10c. City. Town or Location 10b County 28a-f ehow the Medical Exeminer must be notified at 1 ☐ Yes 2 No Director Westminster Carroll 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code or iteme 23a or 21157 TISA 537 Willow Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 194 11. Marital Status 1945 filed withIn 72 hours after 1 ☐ Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates: Specify: 1947 White ģ 3 ☐ Widowed 4 ☐ Divorced 'natural' Completed 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Efementary/Secondary (0-12) other then Storeroom Supervisor Congoleum .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If item 27 te marked other t jury or other traumatic event, in 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ( Gertrude Lease Harvey Harrison Munshaur 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Westminster, MD 537 Willow Avenue Naomi Munshaur/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Meadow Branch Cemetery 8/15/2006 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service Livinses Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 Approximate fnterval Between Onset and Death 23a. Part 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) CARDIOGENIC SHOCK **Physician** /Medical Due to (or as a consequence of): Examiner ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Completed by Physician/Medical the use as IF FEMALE: 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? signed by the atte to be detached for 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 🗆 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 1 Yes certificate Division of Vital or Attending Physician: 26. Pface of Death | Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Tes 1 Inpatient ဥ 2 ER/Outpatient 3□ DOA After thi 28a. Dare of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c Certification: 1 Natural 2 Accident 5 Pending after death.

I Director: Af
d in by the fur investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide within 24 hours after To the Funerel Direct 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MZL D 30263 AVIFOI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO. M. D. , 7601 OSLER DRIVE TOWSON, MARYLAND 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar AUG 14

			1 - For State Registrar	State of Marylan	d / Depa <i>Cer</i>	artmen <i>tificat</i>	t of Heal	ith and M ath		ene 2 () [ g. No,	16	27022
			1. Decedent's Name (First, Middle, Last)						2. Date of Death Month		'ear	3. Time of Death
	Physici		Louise D.	McIntyre					Avayst	11 20		21:09 4
	/Medio Examir		4a. Facility Name (If not institution, give st.	reet and number)		4b. City,	Town, or Loca	ation of Death	7	4c. County of		
			PENINSULA REGIONA!	Mesum		5	4418841	4		Nicon	NICO	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under Months		Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day,	Year)	Birthpl Coun	ace (State or Foreign
	Director		214-10-0309	M 2/4 90	Yrs.				08/03/1	916	lary	<u>land</u>
	pu &		Usual Residence of Decedent  10a. State 10b. County	10c. City	/. Town or Lo	cation					10	Od. Inside City Limits
	ehow	5	,		-74-1							1 Yes 2 No
	158-1	ect	MD Wicomico	5 5	alisbu	10f. Zip	Code		10	g. Citizen of Wh	at Coun	trv?
	A P	<u>a</u>	1733 Riverside Di	rive			2180	)1			JSA	,.
	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow ha Modical Examinar maal be notified at	by Funeral Director		2. Was Decedent Ever in U.	S. 13. V	Nas Dece	tent of Hispan	nic Origin? (Sp	ecity Yes or No-	14. Race -		an Indian,
10	fer d	듄	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ZNo		fYes, spe	cify Cuban, M	exican, Puerto	Rican, etc.)		White, e	etc.
21215-0036	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	200 No Sp	pecify:		Specify:	W	hite
9	72 ho	Completed	15. Decedent's Education (Specify only highest grade				al Occupation	g most of work		6b. Kind of Busi	ness/inc	lustry
21	thin thin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT u	se retired)					
21	ygier t	Co	12	none	Воо	kkee				Bookkeej		
pu	ital H d oth	Be	17. Father's Name (First, Middle, Last) Walter Dryden						(First, Middle, M	aiden Sumame)		
78	i Mer narke	၉		- D==1	10h Mailie				a Dryden	City or Tourn St	ata Zin	Code
Maryland	12 st h and 7 ie n traun		19a. Informant's Name/Relationship (Typ	· ·	100000					5555000	ate, zip	Code
o,	ges 1 end 2 should be filed within 72 hours after death with the Maryla It of Heelih and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28s-f show or other traumatic event, If a Modical Examinar mant be notified at		Vickie McIntyre/Da 20a. Method of Disposition	20b. P	lace of Dispo	sition (Nar	ne of		ury, MD	0c. Location - C	ity or To	wn, State
ō	ages of of t: # it		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	hinetory, crer	•	other place) 1. Cem.	8/15	/2006 SI	had Poir	nt i	Maryland
Baltimore,	permit. Pages 1 end 2 should be filed within Deparament of Heelih and Mental Hygiene. Important: if item 27 ie marked other than 'any injury or other traumatic event, III a Magnete.		1. Signature of Funeral Service License	- '						nad 1011	10,	nary rand
Ba	Depa impo any ir		Samon & Aliun	(a) D				Facility Home			м	n 21952
			3a. Part1. Enter the disease, or complic shock, or heart failure. List only one	M00295 ations that caused the death	n. Do not ent	er the mod	Somers le of dying, su	ich as cardiac	., Prince or respiratory arre	st,	اللب و:	Approximate Interval Between
	Physician		Immediate Cause (Final	ASPIRA +		PA	PUM	ONIa	-			Onset and Death
	/Medical	V	disease or condition resulting in death)	Due to (or as a consequence)								
	Examiner		b	Carpial	Dy	ISRI	hThm	( 2				
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events c.	Due to (or as a consequence	uence of):				<del></del>			
	ate be executed hysicien and the burial-transit	Examiner	Cause (Diseese or injury that initiated events resulting in death) Last									
90,	death certificate be execu e attending physicien and of for use as the burial-tra	EX	resulting in death) Last	Due to (or as a consequent	uence of):							
8760,	hysic the b	dicai	d.									
9	eath certific attending p I for use as	Me.	IF FEMALE:	c. If yes, outcome of pregna	.nov					00.1.0		
Вох	attend for us	ian	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I déath 3[	Ectopic p				23d. Date Montl		ny Day Year
P.0.	y the s	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at time of di 9☐ Unknown	Bath St	J Other (St	эөспу)					
	res that the de igned by the be deteched	モ	Part II. Dther significant conditions cont	ributing to death but not res	ulting in the u	nderlying o	ause given in	Part I.	23e. Did tob	acco use contrib	ute to th	e cause of death?
ds,	8 6 6	Completed by							1 □ Ye	s 2 <b>2</b> No 3	☐ Prob	ably 4 ∐Unknown
20	- 0 =	ete							24a. Was an	24b. We	ere autoi	psy findings available
Re	sician: The law certificete has t irector, pege 2 s	mc							autopsy	pri egt? de	or to cor ath?	npletion of cause of
a	ificeto or. pe	ပိ	25. Was case referred to medical				26	Place of Deat	1 ☐ Yes 2 n (Check only one		Yes	2 No
5	Physician: this certific ral director,	To B	avaminar?	ospital:	ER/Outpatier	nt 3 🗆 D0	Other		me 5 Reside		(Specifi	()
ō			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injury at Work?		28d. Describe ho			
io	Attending P r death. sctor: After the funeral	atio	1 XNatural 5 Pending 2 Accident investigation	(Morial, Day 7 oa)	прагу	М	1 ☐ Yes	2 □No				
Division of Vital Records,	er de recto	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, sti	eet, factor	y, office		28f. Location (Str City or Town		or Rura	l Route Number,
	ital o irs aft rei Di led in											
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier  (Check only one)  1 ★ Certifying Physical Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred vestigation	at the time, d i, in my opinio	ate and place, n, death occur	and due to the ca red at the time, da	use(s) and man te and place, an	ner as st d due to	ated. the cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier	and mainter states.		29	c. License nu	mber	29	d. Date signed	Month,	Day, Year)
	⊢ ≯ ⊢ ŏ		Vaul R. 20	Sun MO			1248	872		8/14/0	6-	
			30_Name and address of person who cor	mpleted cause of death (Item	n 23a) (Type.	Print)			e City	/ //		
_			PAUL Fleury	305 TE	NTA	51	100	camak	e City	MO	218	51
	St Regist	ate rar	31. Date filed (Month, Day, Year)  ALIG 1 5 2	32. Registrar's Signa	iture	1	۔۔۔					

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MATHIAS 1256 PM **Physician** SARA AUGUST 2006 JOYCE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TY HOSPITAL BALTIMORE THE JOHNS HOPKINS If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1□M 200 F 58 261-88-4273 12/24/1947 PENNSYLVANIA Director Usual Residence of Decedent 10c, City, Town or Location 10d Inside City Limits 10a State 10b. County r then "natural", or items 23a or 28a-f show the Medical Exacting must be notified at 1 ☐ Yes 2 🕅 No ACCOMACK VIRGINIA ONANCOCK Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17187 CASHVILLE ROAD 23417 U.S.A. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) GRAPHICS **OWNER** 5+ d other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any july or other traumatic event 90Rg. Be MARY LOUISE WILEY ANDREW D. NICHOLSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROBERT STUART MATHIAS/SPOUSE 17187 CASHVILLE ROAD, ONANCOCK, VA 23417 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State SALISBURY CREMATORY 08/14/06 SALISBURY, MARYLAND 5 Other (Specify) 21. Signatur of Fundral Service Licensee 22. Name and Address of Facility WILLIAMS FUNERAL HOME, 94 MARKET ST., ONANCOCK, VA 23417 nt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Irmediate Cause (Final disease or condition resulting in death) FORTAL VEIN THROMBOSIS ZWEEKS **Physician** /Medical Due to (or as a consequence of): 3WEEKS Examiner LOLANGIO CARUNOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical attending to IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) be detached o 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 CUnknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No has med? 2 A No 1 ☐ Yes Vital Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA ŏ lours etter death.
neral Director: After this
filled in by the funeral di this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification; Division 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide ö To the Hospitel within 24 hours e To the Funeral I completely titled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signatur, and title of certific HO, PhD AUGUST 12, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JU. Marine and address of person who completed cause of death (Item 23a) (Type, Print)

THERESA L. HARTSELL GOO NORTH WOLFE STREET BANTMORE 21297 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Bleen & Specie Registrar

			1- State of Maryland State of Maryland		rtment of F			giene Reg. No.	006	27024
		¥	Decedent's Name (First, Middle, Last)				2. Date of De	ath		3. Time of Death
	Physici		Evelyn Schneider Money				Month 8	9 Day	2006	11:50 P <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. (	County of Death	
			Atlantic General Hospital		Berlin	ı			Worcest	er
	. Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	**	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 12/16/	th y, Year)	9. Birth	
	Director		577-03-3680 96 Usual Residence of Decedent	Yrs.			12/16/	1909	Wash:	inton, D.C.
	land ow		10a. State 10b. County 10c. City, T	own or Loc	ation				Ţ.	10d. Inside City Limits
	Mary Ined	tor	MD Worcester Oc	ean C	itv					1 ☐ Yes 2 XNo
Q	h the	Director	10e. Street and Number		10f. Zip Code			10g. Citiz	en of What Cou	ntry?
3	death with the Maryland ms 23s or 28a-f show r roust be redified at	aiD	8705 E. Biscayne Dr.		21842				USA	
J350	r dea	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No Rican, etc.)	- 1	4. Race - Americ Black, White,	
	s after , or ite	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 9 Year or Dates:		☐ Yes 2 No	Specify:		i	Caraltu	ite
7.0,C	72 hours neturel', zical Era	ed b		6a Decede	ent's Usual Occup	ation	_	16h Kin	id of Business/In	
15	iin 72 n "ne Nedic	Completed	(Specify only highest grade completed)	(Give k	ind of work done O NOT use retired	during most of working)	ng	TOD. IXII	or Businessym	dustry
222	filed within Hygiene. Ither then "	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Hom	emaker			Own	Home	
₹8 E	e file al Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,	Maiden :	Sumame)	
100 E	2 should be filed within and Mental Hygiene. is marked other then eumatic event, Ins Mis	70	Louis W. Schneider			Ethel:	Davis			
13/16/1900 08/09/0000 8, Maryland 21	2 sho and is ma		The state of the s			and Number or Rura				Code)
5 8 E	1 and 2 Health tem 27 i					Ocean Ci	ty, MD			
000	Pages 1 nent of H int: If ite		1 E Bunal 2 D Cremation 3 D Aemovas nom State		ition (Name of atory or other place				ation - City or To	
DOC 16 DOC DO Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23s or 28a-f show any injury or other treumatic event, Ite Medical Examples must be molified at ances.		*4 □ Donation 5 □ Other (Specify) Suns  21. Signature of Fune of Service Ligensee		morial F		/2006		rlin, M	
昭 な な	permit. Page Department of Importent: If any injury or once.	Į į	V Man Butal			am St., B		_	uneral 1 1811	Home
	e ·		23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	Do not ente	r the mode of dyir	ng, such as cardiac o	r respiratory a	rrest,		Approximate Interval Between
	Physician			ILMA	-8					Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequen							1 month
	Examine:		Sequentially list conditions		NIESTIA	IAL BLE	er p			LWELL
	led sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ice oi).						
	xecu and al-tra	Examiner	that initiated events c. Due to (or as a consequen	ce of):						
68760,	eath certificate be executed attending physician and for use as the burial-transit	edicai [	d							
	tificat ng phy as th									
Вох	th certif	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal de		Ectopic pregnancy	<i>y</i>		2	3d. Date of delive	
O. E	0 0	Physician/M	in the past 12 months?  1 Yes 2 DNo 9 Unknown  9 Unknown		Other (specify)				Month	Day Year
<u> </u>	res that the de signed by the a be detached f	Phy	Part II. Other significant conditions contributing to death but not resulting	a in the un	doshilog oguso gru	on in Part I	23e Did t	obacco us	e contribute to t	he cause of death?
7 3480 cords, F	v requires that the been signed by th should be detache	by	NONE	ig iii tili <del>o</del> tilii	derlying cause giv	on mranti.			No 3 Prot	J
326	~ Q 70	etec	7110.							
$\frac{1}{2}\frac{1}{2}\frac{2}{2}\frac{8}{8}$	ne law has l	Completed					24a. Was autor perfo		prior to co death?	psy findings available mpletion of cause of
2 WE	n: Th ficate or, pag		25. Was case referred to medical				1 ☐ Yes	200 No	1 ☐ Yes	210 No
> 0	sicie s certi	o Be	examiner?	/Outpatient	3□ DOA Oth	26. Place of Death			Other (Specif	(4)
10 P	g Phy er this	<del> </del>	27. Manner of Death 28a. Date of Injury 28	b. Time of	28c. Injur Wor	y at 2	28d. Describe I			y)
27.0	nding ath. r: Afte	atio	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury		Yes 2 □ No				
DOC H 5 ivisi	er des rector	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office	2	28f. Location (S City or Tox		Number or Rura	al Route Number,
SS	oitel or urs aft arel Di									
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has I completely filled in by the funeral director, page 2.8	edicai	29a. Certifier  (Check only one)  1 Sertifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	age, death and/or inve	occurred at the tirestigation, in my o	me, date and place, a ppinion, death occurre	and due to the ed at the time,	cause(s) a date and	and manner as s place, and due to	tated.  the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier		29c. Licens			29d. Date	signed (Month,	Day, Year)
			PW		DO	050821	5	8/1	0/06	
4	3A 20		30. Name and address of person who completed cause of death (Item 23 LAZAAK EN (OLA 9733	Ba) (Type, P		1 Prive		n	42 21	811
Į.	Sta		31. Date filed (Month, Day, Year) 32. Signature			V				
0.0	Regist	rar	AUG 1 4 2006 Blace B	1	ode)					

State of Maryland / Department of Health and Mental Hygiene UUU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Month **Physician** 7:52 P.M 2000 Lvnn Munson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1**∑**M 2□ F 93 Yrs. Director MD 220-18-026<u>6</u> September 16,1912 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Be Completed by Funeral Director MD Washington Hancock 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21750 USA 4756 Munson Lane 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 ₩idowed 4 Divorced White naturel". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Depertment of Health and Mental Hygien Importent: If item 27 ie marked other tt. any injury or other treumatic event, the once. 12 Equipment Operator Sand Mining 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Lewis Munson Clara Margaret Boden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charity Miller/Dauchter 15002 Green Lane Road Hancock, MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Warfordsburg Presbyterian 108/18/06 Warfordsburg, PA 21. Signature Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home.P.A. Hancock.MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Righ **Physician** femoral /Medical Due to (or as a consequence of) Examiner RRY cn5 HV 02 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sicien and burial-transit The law requires that the death certificate be executed Atr. a Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Tilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 Tyes 2 1 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ No 1 \_ Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi 27. Mannes of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fu М 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 16 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0060 16 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 6 nurske 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 2 5 2006

			1 - For State Registrar	State	of Mar	yland / I		rtment of			Mental H	ygiene Reg. No	E U .	16	27026
			1. Decedent's Name (First, Mid	dle, Last)						-	2. Date of D	eath Da	v	Year	3. Time of Death
	Physicia /Medic		James Thomas N	Vichols							August	- 4		ग्र	2212PM
	Examin		4a. Facility Name (If not institut	ion, give street and n	umber)	- 1	,	4b. City, Town	n, or Loc	cation of De	ath U	40	. County o	f Death	1 -
			Dorchester	genera		DEATO	1	Carr		Under 24 H			Dar	Ch	eser
	Funeral		5. Social Security Number	6. Sex 1 X M 2 □ F		'In yrs. last bi	rthday) . Yrs.	If Under 1 Ye Months Day		dours M	n. (Month, L	ay, Year,	1016	Coun	lace (State or Foreign try)
	Director		216-09-3220 Usual Residence of Decedent		9	90	113.				March	19,	1910 1	Mary	Tand
	and w		10a. State 10b. Cour	ity	1	Oc. City, Tow	n or Loc	cation						1	0d. Inside City Limits
	Many f sh	Ď	Maryland Dorc	nester		Hurlo	ck								1 ☐ Yes 2 📉 No
	28a	rec	10e. Street and Number	rester		HOLLO		10f, Zip Cod	le			10g. Ci	tizen of WI	nat Cour	itry?
	3a ol	0	5902 Shiloh Cl	nurch Road				21	L643				USA		
	death	Funeral Director	11. Marital Status	12. Was De	cedent Ev		13. V	Vas Decedent	of Hispa	nic Origin?	(Specify Yes or Nerto Rican, etc.)	lo-		- Americ , White,	an Indian,
6	after or Ite	Ē	1 ☐ Never Married 2 💢 M	arried 1 X Yes	2 No	1945-		☐ Yes 2XI		Specify:	ono moan, oro.)		Specify:		
5-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show dical Examiner must be notified at	d by	3 Widowed 4 Divord	ed Year or	Dates:	1747	1							AATI	
5.	72 h natu	ete		ent's Education hest grade completed	1)	16a	. Deced	lent's Usual Oc kind of work do OO NOT use re	cupation one durin	n n <i>g m</i> ost of v	vorking	Ret.	(ind of Bus	iness/lnd	dustry
2121	within iene. than	m	Elementary/Secondary (0-12	) College	(1-4or 5+)	Oz		/Operat					cery	Stor	e
ame	filed within Hygiene. other than "	Be Completed	10 17. Father's Name (First, Midd	le. Last)				/ - F	_	. Mother's N	lame (First, Midd				
$ \zeta\rangle$	d la b	To Be	Thomas Frankl							Evadn	a Wheatl	ey			
SIZ	should ind Men	1	19a. Informant's Name/Relation	nship (Type, Print)		19	b. Mailin	g Address (Str.	eet and	Number or	Rural Route Num	ber, City	or Town, S	tate, Zip	Code)
TO Ž	and 2 ealth a n 27 is		James B. Nich	ols/Son		5	953	Green I	Poin	t Roa	d, East	New	Marke	t, M	D 21631
- ( ) e	es 1 and 2 of Health of item 27 I	-	20a. Method of Disposition			20b. Place o	of Dispos	sition (Name of	f place)		Date	20c. L	ocation - C	ity or To	wn, State
mor Z	Pages nent of I int: If it		1 XBurial 2 Crematic		n State			hingtor		n. 8/1	0/2006	Hur	lock,	Mar	yland
a iii	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Servi	A Licensee	00	,	22	Name and Ad	ddress or	f Facility	me, P. O	Bo	v 207		
m C	89 1 2 8	1	Beuwe	La. a	ell.	u	10	6 Main	Str	eet,	East New	Mar	ket,	MD 2	21631
		(	22. Parv. Enter the disease ck, or heart lailure. L	o complications that is only one cause or	t caused the	ne death. Do	not ente	er the mode of	dying, s	uch as card	iac or respiratory	arrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	GA	STRO	WITE	37;	WAL	1-1	Qua	PRHAGE	_			Onset and Death 5 DAYS
	/Medical Examiner		resulting in death)	Due t	o (or as a	consequence	of):								
	LAdillilei	L	Sequentially list conditions,	b. CA	UE	consequence	<del>-</del> (	COLOT	4	<u></u>					
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	4	U (UI as a	consequence	01).								
	be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c. Due t	o (or as a	consequence	of):							-	
8760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	dicai E													
687	ficate g phys is the	edic		d.											
Вох	leath certific attending pl	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o				Te					23d. Date	of delive	ery
m.	res that the death signed by the atter the detached for	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre	gnant at ti	Fetal deat me of death		]Ectopic pregna ] Other (s <i>pecif</i> y					Mon	th	Day Year
P.O.	t the by the	hys	9 🗆 Unknown	9⊡ Uni	known							-			
	ss tha	by P	Part II. Other significant cond	litions contributing to	death but	not resulting	in the ur	nderlying cause	given ir	n Part I.	23e. Die				ne cause of death?
of Vital Records,	w require been si should t	ted									- 10	Yes 2	No	3 Prob	ably 4 Unknown
ဝင	e lawr has be je 2 sh	ompleted									_ 24a. Wt	opsy	pr	ior to co	psy findings available mpletion of cause of
<u>~</u>	The ate h page	Con					`				pe. 1 ☐ Yes	rfórmed? 2 <b>5</b> 0N		eath? ] Yes	2 🗆 No
/ita	clan: ertific	Be (	25. Was case referred to med examiner?							6. Place of 0	eath (Check onl	( one)			
- J	Physician: The la r this certificate has ral director, page 2	2	1 ☐ Yes 2 ☑No		Inpatient		-	1 3 DOM			Home 5 ☐ Re				y)
u c	ding P h. After funera	ion:	27. Manner of Death  1 SNatural 5 Per		te of Injury onth, Day	Year) 28b.	Time of Injury		Injury at Work?	s 2 □ No	28d. Describ	e now inju	ary occurre	а	
Sic	ttendik death. ctor: A y the fu	icat	3 ☐ Suicide 6 ☐ Coi	estigation ald not be 28e Pla	ce of Injur	v - At home	arm str	eet, lactory, off		, 20110	28f. Location	(Street a	nd Numbe	r or Rura	I Route Number.
Division	al or Attend after death   Director: / d in by the f	Certification:	4  Homicide det	ermined 200. Fla	lding, etc.	(Specify)	idini, Sti	oot, radiory, on	100			own, Stat			
	spita nours neral	aic	29a. Certifier Certi	ying Physician: To t	the best of	my knowledg	je, death	occurred at th	ne time,	date and pla	ace, and due to th	e cause(	s) and mar	ner as s	tated.
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical	(Check only one)	el Examiner: On the and ma	basis of e anner state	examination a ed.	nd/or in	vestigation, in n	ny opini	ion, death o	ccurred at the tim	e, date ar	nd place, a	na due to	o tne cause(s)
	To the within To the comp	Ž	29b. Signature and title of cer	Pier	2	. 5		29c. Lic	ense nu	umber		29d. D.	ate signed	(Month,	Day, Year)
			11/0	1	1 1	10		Do	) LC	2040	)	8/	6/0	P	
			30. Name and address of pers	on who completed ca	use of dea	ath (Item 23a	(Туре,	Print	.Δ.	-	- 10	000	1		91. 19
_			CRASG J.	CHACT-C	VC. L	u D	10	OF SAM	UXE	201	, CHEY!	JK-21.	KF,	ure	2613
	Sta Regist	ate rar	31. Date filed (Month, Day, YA	0 2006	A GAR	's Signature	E.	and a							

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Date of Death Physician/ Month Day August 17, 2006 0948 hrs Medical Examiner Eric Nelson Gregory 4a. Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death 4c County of Death **Baltimore County** Pikesville 3701 Old Court Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Foreign Country) Hours Min Director 39 213-88-7094 1 XM 2 06-19-1967 MD Usual Residence of Decedent 10d Inside City Limits IOc City, Town or Location 10b County 10a State 1 Yes 2 X No 28a-f show 23a or 28a-f show notified at once. Carroll Hampstead MD death with the Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21074 **USA** 4462-421 Woodsman Drive 這 Funeral 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 11 Marital Status must be 1 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married Married Yes White Specify Divorced If Yes, Give Year 1 Yes 2 X No specify: hours after 3 Widowed 27 is marked other than "natural", ımatic event, the Medical Examiner 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry rement of Health and Montal Hygiene tant: If item 27 is marked other or other traums\*\* Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 HVAC Technician Contracting 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nelson - Father S. Fields Nancy Be Cecil Eric 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecil Eric Nelson - Father 205 Fender Ct., Havre De Grace, MD 21078 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a Method of Disposition crematory or other place) Important: If Burial 2 X Cremation 3 Removal from State Carroll Cremations 08-23-06 Hampstead, MD 21074 Other Specify: Donation 5 22. Name and Address of Facility Eline Funeral Home Signature of Funeral Se 934 South Main St., Hampstead, MD 21074 MOO550 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Mixed alcohol and cocaine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical X UNPENDED AMENDED signed by the attending physician be detached for use as the burial -.g858,8/29/06 TT item#23a,27, 28a-f.perME. P.O. Box 68760, IF FEMALE: 23d Date of delivery 23c. If yes, outcome of pregnancy 23b Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? ✓ Yes 2 No ✓ Yes 2 No After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 examiner? Other<sub>4</sub> DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 1 🗸 Yes No 28c. Injury at Work? 28d Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Natural 1 Yes 2 X No after death. Pending Fnd 8/17/2006 the Fnd 9:30 am unk 2 Accident Investigation 28f Location (Street and Number or Rural Route Number, City or Town, State) 3701 Old Court Road Pikesville, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be determined (Specify) Fnd: roadway (in parked car) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the To the 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and O.C.M.E August 18, 2006 HUIT 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD. 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG Registrar

DHMH 17 Rev 1/2001 OCME 2006

			- State Registrar	te of Maryland / [	Department of H Certificate of L	ealth and M Death	Reg. I		27023
	Physici		Decedent's Name (First, Middle, Last)     Luis Antonio Osc	orio-Fernande:	Z		2. Date of Death Month	Day Year	3. Time of Death 4.25A <sub>M</sub>
<i>}</i>	/Medio Examin		4a Facility Name (If not institution, give street a	the Lak	e Salis	Location of Death	MD	4c. County of Dea	OVALCO
	Funeral Director		5. Social Security Number 6. Sex 154 M 20	7. Age (In yrs. last bir	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes July 21,	9. Bir 1971 Pue	thplace (State or Foreign ountry) erto Rico
	Maryland I-f ehow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town					10d. Inside City Limits
5	the Ma 28a-f	Director	MD Dorchester		Cambr	idge 	100	Citizen of What Co	1 X Yes 2 □ No
5	h with		208 West End Ave., A	Apt. B		21613		USA	Surity:
	be filed within 72 hours after deeth with the Marylar it all Hyglene. Id other then "natural", or Itema 23a or 28a-f show other then "natural", or Itema 23a or 28a-f show event, the Madical Examination at the notified at	Funerai	Am	s Decedent Ever in U.S. ned Forces? Yes 2 2 No	13. Was Decedent of Hi If Yes, specify Cuba			14. Race - Ame Black, Whit	
5-0036	nours at	þ	3 ☐ Widowed 4 ☑ Divorced Yes	es, Give ar or Dates:	1⊠Yes 2□No		to Rican		ispanic
215-	thin 72   e. en "nat	Completed	15. Decedent's Education (Specify only highest grade comp		Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	turing most of worki )	ng	. Kind of Business	
2	ited wii Hygien ther th	Con	12 17. Father's Name (First, Middle, Last)		forklift	operator	(First, Middle, Maid	frozen :	food
/lanc	2 should be to and Mental His marked of reumatic even	To Be	Carlos Osorio				Emille Fe		
Maryland 2121	s 1 end 2 should if Heelth and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Pri Miqdalia Osorio		. Mailing Address (Street a				
altimore,	00	li	20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Remova	20b. Place of	Disposition (Name of ry, crematory or other place			Location - City or	
ij	permit. Pages Department of Importent: if It any Injury or o		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		oury Cremato 22. Name and Addres			alisbury	
B	Dep con	ds d	I that know		700 Locust	St., Cam	bridge, M		I. A.
	Physician		23a. Pan\( \frac{1}{2} \) Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final	e on each line.	•			0 –	Approximate Interval Between Onset and Death
5	/Medical Examiner		disease or condition resulting in death)	ETASTATION TO THE TOTAL STATION TO STATION T	of):	th Con	RCINOI	4/1	
		Jer	Saturentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	due to (or as a consequence	01):				
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8760,	ate be e hysicier he buris	dical E	d					4	Use (co.
Box 68	eath certifici ettending pl	/Med	IF FEMALE: 23c. If y	es, outcome of pregnancy				23d. Date of de	livery
Ö.	The law requires that the death certificate be executed to has been signed by the ettending physicien and otge 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	Live birth 2 Fetal death Pregnant at time of death Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
<u>ഗ്</u> വ	res that the de igned by the e be detached f	þ	Part II, Other significant conditions contributing	ng to death but not resulting is	the underlying cause give	en in Part I.			o the cause of death?
Records,	s been si	Completed					24a. Was an	24b. Were a	utopsy findings available
al Re		Com					autopsy performed 1 Yes 2	? death?	completion of cause of
Vital	Physician: Th this certificate ral director, peg	o Be	25. Was case referred to medical examiner?  1 \(\sum \) Yes 2 \(\sum \) No Hospita	: 1 X atient 2 ☐ ER/Ou	tpatient 3 DOA Othe	26. Place of Death	n <i>Check</i> only one me 5 ☐ Residence	6 □Other /So	20164
n of	ding Phys h. After this funeral di	on: T	27. Manner of Death 28a  1/ ■ Natural 5 □ Pending	Date of Injury 28b. 1	Time of 28c. Injury	at :	28d. Describe how in		wiyj
Division of	tor: the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e	Place of Injury - At home, fa		Yes 2 □No	28f. Location (Street City or Town, St		ural Route Number,
۵	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by		29a. Certifier 194 Certifying Physician:	To the best of my knowledge	e, death occurred at the time	ne, date and place,	and due to the cause	e(s) and manner a	s stated.
	To the Hospital within 24 hours of To the Funeral completely filled	Medicai	(Check only 2 Medical Examiner: Or one) an	n the basis of examination and manner stated.	d/or investigation, in my of	oinion, death occurr	ed at the time, date a	and place, and due	e to the cause(s)
P	with con		29b. Signature and title of certifier	40	29c. License			Date signed (Moni	
			30. Name and address of person who complete		(Type, Print)	- 0 // 0		-11.5/	06 no 2120/
	Sta	ite.	31. Date filed (Month, Day, Year)	32. Regitrar's Signature	- W.	NOOD (	JT. SAL	1513URY	ND 2120/
	Registi		AUG 1 4 200	Streve B	Special				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Month 12:20PM August 2006 JAMES OSTERLING STEG /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jan 223, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1946 15 M 2□ F Pennsylvania 186-34-4666 60 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "naturel", or items 23e or 28e-f ehow the Medical Examinar must be notified at Frederick Maryland Frederick 1 Yes 2 No Director 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zin Code 21703 3400 Basford Road daath v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: Vietnam Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filad within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) I.T. Computer permit. Pages 1 and 2 should be filed v Department of Health and Mantal Hygies importent: If item 27 is marked other tt any injury or other treumatic event, III.s once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Osterling Charlotte Godwin Wilhelm Steg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3400 Basford Road, Frederick, Maryland 21703 19a. Informant's Name/Relationship (Type, Print) Mrs. Gail Osterling / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rolling Green Cemetery Aug 23, 2006 Camp Hill, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Fune al Service Licensee <sup>22, Name and Address of Facility</sup> Keeney & Bastord P.A. Funeral Home M00706 106 East Church St, Frederick, Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 4 days Physician Piration pneumonia /Medical Due to or as a onsequence of): Examiner francelear palsy 100 1128 IVR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death cartificate be executed ding physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as tha IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No this certificate 1□ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Autonomia 24 hours after death.

To the Funeral Director: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 - Homicide 29a. Certifier 1> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Mo 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) Ld Woodsbon, Cullermine 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 5 2006 Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:00 William Franklin Parks 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester General Hospital Dorchester Cambridge If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 191M 2□F Yrs. 217-14-8714 Director 85 July 24, 1921 Maryland Usuel Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 27 is marked other than "natural", or items 23s or 28s-1 show traumatic event, the Medical Examt at must be inclifted at MD Dorchester 1 ☐ Yes 2 XNo Cambridge Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3001 Steamer Run Road 21613 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗹 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) project superintendent construction 11 yermit. Pages 1 and 2 should be file.
Department of Health and Mental Important: If item 27 is —
any injury or or—
any file. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Arthur Parks Nellie Creighton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 212 Linthicum Dr., Cambridge, MD 21613 Pamela J. Parks daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Memorial Park 8/12/06 Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to limit ediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed burial-transit è attending physician and resulting in death) Last Due to (or as a consequence of) Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2DNO or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 No 1 1 patient 2 ER/Outpatient 3□ DOA this After thi 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending r death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the within 24 hours after deat To the Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier me and address of person who completed cause of death (Item 23a) (Typ aman 31. Date filed (Month, Day, Year) AUG 1 0 2006 State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For State Registrar	State of Maryland		artment of H		and Men	tal Hygie	- 4000	27031
	45		Decedent's Name (First, Middle, Las	t)					ate of Death	D	3. Time of Death
	Physicia		Walter Allen	Payne In					Month ugust	8 200	6 5:00PM
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location o			4c. County of Dea	
			Holy Cross Hos	spital		Silver	Spr	ing		Montgom	ery
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. la:	, ,	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. C	pate of Birth Month, Day, Ye pt. 16	9. Bir	thplace (State or Foreign puntry)
	Director		229-46-74891 4	ŽM 2□F 66	Yrs.			Se	pt.16,	,1939 Vi	rginia
	DQ &	}	Usual Residence of Decedent  10a, State 10b, County	10c. City.	Town or Lo	cation					10d. Inside City Limits
	anyla aho	ក	MD Prince		n Hil						YQYes 2□No
	28e-f	ect	10e. Street and Number	seorges oxor	1 111 1	10f. Zip Code			10g.	Citizen of What C	
:	Will Will	直	8 Alexandria O	verlook Drive	2	20745				JSA	<b>,</b>
	18 23 18 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S		Was Decedent of H f Yes, specify Cuba	ispanic Orig	gin? (Specify		14. Race · Am	
<b>.</b>	fer d	들	1 Never Married 20 Married	Armed Forces? 1 ☐ Yes 2 ☐XNo	1	f Yes, specify Cuba 1 □ Yes 2 No		i, Puerto Rica	n, etc.)	Black, Whi	
ဗ္ဗ	filed within 72 hours after deeth with the Maryland Hygiane. Ither than "natural", or Items 23a or 28e-f ahow ant, tra Madical Examinar must be notified at	Ď	3 Widowed 4 Divorced	If Yes, Give 22 Year or Dates:		1 ∐ Yeş 2{⅓ No	Specify:			Specify: B]	ack
Maryland 21215-0036	72 ho	Completed by	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Deced	dent's Usual Occup	ation	t of working	168	o. Kind of Business	/Industry
2	E 0 E	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	1)				
2	ygiar t	Š			Physi	ical Che				S. Gove	ernment
ב	tial H	Be	17. Father's Name (First, Middle, Last)						st, Middle, Mai	den Surname)	
3	ould Merka narka	5	Walter Allen P		10h Mailie	a Address (Ctrast		la Re		ity or Town, State,	Zin Codel
Mai	12 sh hand 7 te n treun		Mary W. Payne			•					L1,MD20745
e,	permit. Pages 1 and 2 should be filed within 72 hours atter deeth with the Marylan Depertment of Health and Mental Hydiane. Depertment of Health and Mental Hydiane. Depertment of Health and Mental Hydiane. Depertment of Health and Health and Health and Institute or other traumatic avant, the Medical Exantinal must be notified at any injury or other traumatic avant, the Medical Exantinal must be notified at any injury or other traumatic avant, the Medical Exantinal must be notified at any injury or other traumatic avant.		20a. Method of Disposition					Date		. Location - City or	
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Ba	Depe Impo		1/09/11	MASON						dria, VA	
	_		23a. Part . Enter the disease, or comp shock, or heart failure. List only	plications that caused the death.							Approximate Interval Between
	Thursieine		Immediate Cause (Final	one cause on each line.							Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Sepsis Due to (or as a conseque	ence of):						MOHENS
	Examiner		1	b. Respirator		ilure					months
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	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events	c							
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8760,	icate be executed physician and s the burial-transit	dical		, d.							
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Вох	eath certifi ettending I for use as	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetate 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	1			23d. Date of de Month	Day Year
o	it the de by the tached	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	u 3L						
P.0	that the the the the the the the the the th	ď.	Part II. Other significant conditions of	ontributing to death but not resul	ting in the u	nderlying cause giv	en in Part I.		23e. Did tobac	co use contribute	to the cause of death?
Vital Records,	law requires that the es been signed by th 2 should be detache		Stroke						1 🗆 Yes	2 □ No 3 □ F	robably 4 DUnknown
00	w requir been s should	Completed	Decubitus Ulce	n c					24a. Wasan	24b. Were a	utopsy findings available
Re	0 5 6	E C	Decubilus ofce	1.9					autopsy performer 1 Yes 2 ☑	death?	completion of cause of s 2√0√No
tal	icien: Th certificete rector, pa	0	25. Was case referred to medical				26. Ptace	e of Death (C)	1 Yes 2 ∠ neck only one)	ו מאדנו	s St Man
⋝	Physicien: this certific ral director,	To B	examiner? 1 □ Yes 2 ሺੱNo	Hospital: 1 ☑ Inpatient 2 □ E	R/Outpatier	nt 3 DOA Ott				e 6 □Other (Sp	ecify)
	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju	y at	28d.	Describe how	injury occurred	
Ö	Attending r death. ector: After by the fune	atle	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	n			Yes 2 🗌				
Division	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined			reet, factory, office		28f.	Location (Stree City or Town, S	et and Number or F State)	Rural Route Number,
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	To the within To the comple	Me	29b. Signature and talle of certifier			29c. Licens	se number		29d	, Date signed (Mor	nth, Day, Year)
	- 3 - 0		> Thum	1		D-32	332		0	8/09/06	
0	(5)		30. If me and address of person who	completed cause of death (ttem.	23a) (Type,	Print)	00 -			- MD 0	0000
1			Dr. SK Gupta ·	- 9801 Georgi	a Av	e. ste.	20,5	ılver	Sprin	.g, MD 2	0902
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			For State Registrar	ease	-		d / Depa		Health and I Death	Mental Hy	4.5	006	2703
			Decedent's Name (First, M	iddle, Last	)					2. Date of De	ath		3. Time of Death
	Physici		Shirley	_	nn	F	Plumme	er		Nonth Month	Day 18	O6	18:40 M
1	/Medic		4a. Facility Name (If not instit				10111111		or Location of Death			y of Death	10.10
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_	Freezest		5. Social Security Number	6. Se	x 7.		last birthday)	If Under 1 Year	r If Under 24 Hrs.		th	9 Births	lace (State or Foreign
	Funeral Director		220-30-8197	10	M 2□ <b>火</b>	69	Yrs.	Months Days	Hours Min.	Jul 12	<sup>2</sup> , 1937	Coui	'M'D
			Usual Residence of Deceden			- 00					,		
	land ow		10a. State 10b. Cou			10c. Cit	ty, Town or Lo					1	0d. Inside City Limits
	Mary	ţ	WV N	linera	l		Ridg	jeley					1 ☐ Yes 2 🔀 No
	28a	rec	10e. Street and Number			1		10f. Zip Code			10g. Citizen of	What Cou	ntry?
	A Aith	٥	Rt. 2 Box 20	6					26753		L	JSA	
	Te 2	era	11. Marital Status		12. Was Decede	nt Ever in U	.S. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No	)- 14. Ra	ce - Ameri	
<b>,</b>	r iter	교	1 Never Married 2	Married	Armed Force 1 Yes 2 If Yes, Give					o Rican, etc.)		ick, White,	
93	urs a	þ	3 ☐ Widowed 4 ☐ Divor		If Yes, Give Year or Date	s:		1□Yes 2□No	Specify:		Speci	<sup>∱⁄:</sup> wh	ite
ō	72 hours after death with the Maryland neturel', or iteme 23a or 28a-f ehow deat Examinar munitie rodified at	ted	15. Dece	dent's Edu	cation		16a. Dece	dent's Usual Occu	upation	dela m	16b. Kind of E	Business/In	dustry
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21	d with	5	12				labor	er			Celane	ese C	orp.
B	be filed within 72 hours after death with the Marylan ital Hygiena.  Id other then "neturel", or iteme 23a or 28a-f show event, its Medical Exaction or must be relified at	Be Completed by Funeral Director	17. Father's Name (First, Mid						18. Mother's Nar			me)	
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Maryland 21215-0036	ges 1 and 2 should be filed within it of Health and Mental Hygiena.  If Item 27 is marked other then " or other treumatic event, I.a. Mis.		19a. Informant's Name/Relat		rpe, Print)	- la al	19b. Maili	ng Address (Stree	et and Number or Ru <b>)6</b>	Iral Route Numb	er, City or Town	State Zin	N 26753
	alth alth		Richard Plur	nmer	nu	sband	Rt.	Z Box Zu	)O	Kiug	jeley	٧v	V 20133
Baltimore,	of Health of Health fitem 27		20a. Method of Disposition	• 🗆		0	cemetery, cre	osition (Name of matory or other pl	ace)	Date	20c. Location		
Ĕ	Page nt: ff ny or		1 ☐ <b>St</b> rial 2 ☐ Cremat 4 ☐ Donation_ 5 ☐ Othe		Removal from Sta	<sup>ate</sup> ∣ Ro	ocky Ĝa <sub>l</sub>	o Véterans'	Cemetery	8/22/200	<sup>6</sup> Flints	tone	MD
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			23a. Part Enter the disease hock, or heart failure.	, or comp	lications that cau	sed the deat	h. Do not en						Approximate
		-	ineck, or heart failure. Immediate Cause (Final	List only o	ne cause on eac	rigne.	-1-	and the same of th					Interval Between Onset and Death
3	Physician /Medical		disease or condition resulting in death)	-	a	5044	58	(1116	inoma				14800
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687	death certificate t attending physi I for use as the t			•	d								
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P.O.	the d	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		9□ Unknow		Joann J	_ Other (specify)					
	thet the de ed by the detached	Completed by Physician/Medi	Part II. Other significant con	ditions co	ntributing to deat	h but not res	sulting in the u	nderlying cause g	liven in Part I.	23e. Did 1	obacco use cor	tribute to t	ne cause of death?
Division of Vital Records,	w requires thet s been signed k should be det	b b						, , ,	, , , , , , , , , , , , , , , , , , , ,	10	Yes 2 No	3 🗆 Prot	nably 4 Dunknown
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ě	10 CA	du								24a. Was	an 24b. psy prmed?	Were auto	psy findings available mpletion of cause of
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<u>s</u> .	eath lor: /	cati		estigation uld not be					Tes 2 No				
:≦	irect Irect	#	4 Homicide	ermined	28e. Place of building	Injury - At h , etc. <i>(Specit</i>	ome, farm, st fy)	reet, factory, office	3	28f. Location ( City or To	Street and Num wn, State)	ber or Rura	I Route Number,
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	Hoep 4 hou Fune ely fi	cal	(Check only 2 Med	ifying Phy ical Exam	ner: On the basi	s of examina	wledge, deat	h occurred at the vestigation, in my	time, date and place opinion, death occu	, and due to the	cause(s) and m	anner as s	tated.  o the cause(s)
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification:	One)		and manne	r stated.							
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			My	200	On	asth	M	5	5/35		8	119	106
	le		30. Name and address of per	son who c	ompleted cause,	death (Iter	n 23a) (Type,	Print)	, >	N.		,	106 1 MD
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	Sta		31. Date filed (Month, Day, Y		32. Breg	trar's Signa	ature	E0-					
	Regist	ar	AUG	252	(1006)	2-9-18-1	d.	maste)					

			State of Maryland / Department State   Certification	ent of Health and Nate of Death		ene 2006	2703.
	Physici	an.	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medio		Linda Lee Privett		August		0637 <b>A</b> M
	Examir	er		ity, Town, or Location of Death		4c. County of Death	
				ovre de Grace	8. Date of Birth	Harford 9. Birtho	lace (State or Foreign
۷.	Funeral Director		212-52-8621 1 M 2X F 57 Yrs. Montr		March 22	, 1949 Mar	lace (State or Foreign otry) Cyland
<u> </u>	ō		Usual Residence of Decedent				*
-	arylar show	ايا	10a. State 10b. County 10c. City, Town or Location MD Harford Darlington			1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ba-f	cto			1		
_	with the	Funeral Director		Zip Code	10	g. Citizen of What Coun	try?
$\cap$	eath vs 23	erai	4041 Conowingo Road  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De	21034	acify Vas or No-	U.S.A.	an Indian
) <u>(a</u>	ther d	Ē	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
$\lesssim$ 8	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	i 2 No Specify:		Specify: Whi	.te
$\mathcal{L}$ 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or items 23s or 28s-f show svent, the Madical Examinar must be notified at	Be Completed	15. Decedent's Education 16a. Decedent's U (Specify only highest grade completed) (Give kind of	sual Occupation	kina 1	6b. Kind of Business/Inc	Justry
7 2	- 30	ם	Elementary/Secondary (0-12) College (1-4or 5+)	work done during most of work Tuse retired)			
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and the	Mental be farked of	Be	Gerald Elsworth Pierce	Vivian (		alour obmanie,	
Maryland	s 1 and 2 should be filed within Health and Mental Hygiene Itam 27 is marked other than other traumatic svent, the M	ပ္		ess (Street and Number or Rui		City or Town, State, Zip	Code)
VI -	12 mg		Danny Pierce (Brother) 436 West	Bel Air Ave.	Aberd	een, MD 21	001
re.	os 1 end of Health Itsm 27		20a. Method of Disposition 20b. Place of Disposition (Commeter, Commeter, Co	Vame of or other place)	Date 2	0c. Location - City or To	wn, State
	Peges nent of ant; If It ury or o		1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Harford Mem.	ı	/06	Aberdeen, M	aryland
Baltimore.	permit. Peges 1 el Depertment of Hea Important: if Itsm sny injury or oths once.		21. Signature of Funeral Service Licensee 22. Name	and Address of Facility arring-Cargo F berdeen, Maryl	Tuneral H	ome, P.A.	
2	40 E 3 a		23a. Part1. Enter the disease, exemplications that caused the death. Do not enter the m				Approximate
8760. A	/Medical Examiner bhysicien and in brushicien and in brushicien and in sthe prival-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	A DRENI	EL CA	NCER	Onset and Death
Division of Vital Records, P.O. Box 6	E O of	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic 4 Pregnant at time of death 5 Other	c pregnancy (specify)		23d. Date of delive Month	ory Day Year
rds. F	w requires that been signed I should be det	à	Part II. Other significant conditions contributing to death but not resulting in the underlyin  HYPOYENSION, POSCIBLE  J	g cause given in Part I.	1	accoluse contribute to th ; 2 □ No 3 □ Prob	
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of o	Physic this c	၉				ice 6 Other (Specify	1)
u c	ding P. Atter funeri	io	27. Manner of eath  Adaptar 5 Pending (Month, Day Year)  Accident investigation  M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	v injury occurred	
isi	death death ctor: /	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fac		28f. Location (Str.	eet and Number or Rura	I Route Number.
Ö	atter i Direct	Certification:	4 ☐ Homicide building, etc. (Specify)	,,	City or Town,	State)	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)  Check only one)  Check only one)  Check only one)  Check only one)	ed at the time, date and place, ion, in my opinion, death occur	, and due to the car rred at the time, da	use(s) and manner as st te and place, and due to	ated. the cause(s)
	Totl within Totl comp	X	David C. Buck, M.D.	29c. License number D003694	40 A	d. Date signed (Month,	7, 2006
	5	9	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  South		MORIAL ZUUE, H	AVRE DE	GRACE 2107
	Sta Regist		31. Date filed (Month, Day, Year)  33. Aegistrar's Signature	9	,		

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Adelaide Barnes Ross /Medical August 11 2006 6:12 a. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dorchester 2 Johnson Street Cambridge 8. Date of Birth (Month, Day, Year) July 1,1922 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** New Hampshire 1 □ M 2 🕱 F Yrs Director 016-16-6510 84 Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at XXYes 2 No Plymouth East Wareham Mass. Directo with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 02576 US Ітете 23а 5 Farmers Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 XX0 If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XXX No Specify: Specify: þ 3 Widowed 4 Divorced netural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) loan officer bank 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be filt tment of Health and Mental Hy tant: If Item 27 le marked oth jury or other treumatic event Be Lillian Ethel MacLennan Robert I. Barnes, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5 Farmers Lane East Wareham, MA 02576 Barbara A. Smith Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. 7/12/2006 Salisbury, Maryland Salisbury Crematory 21. Signatur Funeral Service Licensee Thomas Funeral Home, P.A. Kin 700 Locust Street Cambridge, Maryland 21613 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dementiz 34eas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Larry, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physiclen Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificete has 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) daughters 2 Pis After this funeral of 28a. Date of Injury (Month, Day Year) home 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ş 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) anson all 140059973 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Cambridge, MD 21613 Bramble ohnson 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 1 4 2006

DHMH 17 Rev 1/2001

ORIGINAL

1 - For State Registrar	State of M	laryland / Depa	artment of H rtificate of L		R	eg. No.	06 27035
1. Decedent's Name (Fi					2. Date of Dea	Day	Year 3. Time of Death
/Medical Wade	Allen Roche	A	45 Cit. T	Leading of Books	Augus		2006 0225 M
Examiner 4a. Fecility Name (If not Dorches	institution, give street and number	to tal	4b. City, Town, or	Location of Death	0	4c. County	chester
E Copiel Copusity Numb	per 6. Sex, 7. A	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
Funeral 217-42-6040	0 112 M 2□F	62 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day May 27	1944	Mary Land
Usual Residence of Dec	cedent b. County	100 City Town and					10d Inside City Limite
and an	•	10c. City, Town or Lo					10d. Inside City Limits 1 Dres 2 □ No
Maryland  10e. Street and Number	Dorchester		Cambri 10f. Zip Code	ıdge	1	0g. Citizen of W	
417 Talbot			21613	3		og. Olizon of th	USA
te e e e e e e e e e e e e e e e e e e	12. Was Deceden	t Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe	ecify Yes or No-		- American Indian,
9 1 Never Married	Armed Forces 1 □Yes 2 □ If Yes, Give	]No	1 ☐ Yes 2 ☑ No	Specify:	nican, etc.)	Specify:	c, White, etc.
22-0036  Waryland  10a. State  10a. State  10a. State  10a. State  10a. Street and Number  417 Talbot  11. Marital Status  1 Never Married  3 Widowed 4 C  15. (Specify of Specify of Speci	Divorced Year or Dates:	:					WILLE
(Specify of	Decedent's Education only highest grade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation fu <i>ring</i> most of worki )	ing	16b. Kind of Bus	siness/Industry
Street and Number 417 Talbot  Waryland  10e. Street and Number 417 Talbot  11. Marital Status  11. Marital Status  12. Specify  Specify  Elementary/Secondar  12. Specify  Elementary/Secondar  13. Specify  Elementary/Secondar  14. Specify  Elementary/Secondar  15. Specify  Elementary/Secondar  16. Specify  Elementary/Secondar  17. Specify  Elementary/Secondar  18. Specify  Elementary/Secondar  19. Specify  Elementary/Secondar  12. Specify  Elementary/Secondar  12. Specify  Elementary/Secondar  12. Specify  Elementary/Secondar  12. Specify  Elementary/Secondar  13. Specify  Elementary/Secondar  14. Specify  Elementary/Secondar  15. Specify  Elementary/Secondar  16. Specify  Elementary/Secondar  17. Specify  Elementary/Secondar  18. Specify  Elementary/Secondar  19. Specify  Elementary/Secondar  19. Specify  Elementary/Secondar  10. Specify  Eleme	ry (0-12) College (1-4or	5+)	ce Office			Law Enf	orcement
17. Father's Name (Firs	t, Middle, Last)			18. Mother's Name	e (First, Middle,		
Baltimore, Maryland 21215-0036  Pearlimore, Maryland 21215-0036  Pearlimore, Maryland 21215-0036  Maryland 10e. Street and Number 417 Talbot 10e. Street and Number 417 Talbot 21 marked other then natural to other then na	. Roche				Jean	Hurley	
19a. Informant's Name	Relationship (Type, Print)		ng Address (Street a				
Nancy Knox	Roche/Wife	20b. Place of Dispo	7 Talbot A				013 City or Town, State
20a. Method of Disposit	remation 3 Removal from State	cemetery, cre	matory or other place	θ)			
*4 Donation 5	1						ce, Maryland
Band of Department of Physics of	isease, or complications that cause	UTER !	Curran-Bro	omwell Fu	neral Ho	ome, P.A	
23a. Part1. Enter the d	irease, or complications that cause	ed the death. Do not en	ter the mode of dying	g, such as cardiac	rage, Por respiratory arr	<del>1D 216</del> 1 est,	Approximate Interval Between
Physician Immediate Cause (Finadisease or condition	al Arbriz	schulie	Hear.	- Ditca	er		Onset and Death
/Medical resulting in death)	Que to (or a	s a consequence of):					
Examiner Sequentially list conditi	ons. b. Preud	werei					
Sequentially list condition if any, leading to immediate the cause. Enter underlying cause. Enter underlying that initiated events resulting in death) Last	diate Due to (or a	s a consequence of):					
that initiated events resulting in death) Last	C.	s a consequence of):					
carse Enter Order to the control data in the purpose of the control of the contro							kee a see a see a see a see
Attending Physician of Vital Records, P.O. Box 68760, Attending Physician of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed clearly.  According to the attending physician and sector. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detected for use as the burial-transit of the physician and physician	0.						
BOX 6 eath certific eath certi			⊒Ectopic pregnancy				of delivery
wrequires that the death wrequires that the death been signed by the atternation of the peer signed by the atternation of the peer signed by Physician of the peer signed by Physician of the peer 1 o	ITINS!		Other (specify)			Mon	th Day Year
O. a the sea of the se	nt conditions contributing to death	but not reculting in the	and or heing on use one	on in Part I	23e Did to	hacco use contri	bute to the cause of death?
Spanning Spanning Part II. Other significar	colon Car	-	inderlying cause give	21 H H T CATC 1.			3 robably 4 □Unknown
v requires should be shoul					24a. Was a		Vere autopsy findings available
al Record  The law requir cate has been si page 2 should  Completed					autops perfori	med? de	nor to completion of cause of eath?
Vital Relation The later than the la	to medical			26. Place of Death		7	□Yes 2€No
examiner?	Hospital:	tient 2 ER/Outpatie	nt 3 DOA Othe	The second	me 5 ☐ Reside		r (Specify)
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Division of Vital Records, let or Attending Physician: The law requires t is after death.  In a line d	determined 286. Place of It	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, office		28f. Location (Si City or Town		r or Rural Route Number,
Ten Sun De la Certifier 19	Certifying Physicien: To the bes	t of my knowledge, deat	h occurred at the tim	ne, date and place	and due to the c	ause/s) and mar	oner as stated
	Medical Exeminer: On the basis and manner s	of examination and/or in					
29b. Signature and title			29c. License	number	2	9d, Date signed	(Month, Day, Year)
	acylica MD		D4.	7924		8-13	-06
30. Name and address	of person who completed cause of	AURORA	SF CA	MRRIDG	E 10	10 2	(613
State 31. Date filed (Month, I	AUG 1 4 2006	Pr's Signature	Aports.				

			For State Registrar	State of Mary	/land / [	Department of Certificate of			iene 2 ()	106	27037
			Decedent's Name (First, Middle, Last		2. Date of Deat			3. Time of Death			
	Physici	an		Richard	_	5 -		Month O 8	Day	Year 2006	9:00 pM
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			Baltimore Washing 5. Social Security Number 6. S		. Cente		ırnie ir [If Under 24 Hrs.]	8. Date of Birth	Anne		Ie1 lace (State or Foreign
	Funeral			XM 2□F 78	,	Yrs. Months Day		_ (Month, Day,	<sup>Year)</sup> 1928	Count	try)
	Director		Usual Residence of Decedent	/ 0				June /,	1920	remis	ylvania
	and w		10a, State 10b. County	10	c. City, Tow	n or Location				10	0d. Inside City Limits
	Aarylan f show	ō	Maryland Anne An	aun do 1	Arno	.1.4					1 ☐ Yes 2XXNo
	the t	ect	Maryland Anne Anne Anne Anne Anne Anne Anne An	under	AIII	10f. Zip Code		11	Og. Citizen of V	What Count	try?
	with	Funeral Director	1284 Circle Drive			21012			nited S		•
	e 23	era	11. Marital Status	12. Was Decedent Eve	rinlls		f Hispanic Origin? (Spe			e - America	
60	p = 1	Ľ,	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No	1110.3.	If Yes, specify Cu	uban, Mexican, Puerto	Rican, etc.)		k, White, e	
<u>0</u>	Saff	by F	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 N	lo Specify:		Specify	Wh	ite
Richard 5	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. I marked other then "naturel", or Iteme 23e or 28e-f show umatic event. It is Mydical Estruiner nate the notified at		15. Decedent's Ed		16a	Decedent's Usual Occ	upation		16b. Kind of Bu	isiness/Ind	lustry
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7 2	with 8ne.	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)	Adv	vertising S			Newspa	per	
	Hygi The T		17. Father's Name (First, Middle, Last)		114		18. Mother's Name	First, Middle, N			
<b>次</b> 豐	d d o	Be	James Richards				Iona Mae			-,	
Ž	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event.	2	19a. Informant's Name/Relationship (	Euro Orintl	101	Mailian Address (Con				Canan Zin	Code)
S RI Maryland	12 st h and 7 ls r				1	. Mailing Address (Stre					
(1)	and feelth m 27 her tr		James E. Richards	Jr./son		174 Chalk P					and 20778
2 5	Pages 1 nent of H nnt: if ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐			Disposition (Name of ry, crematory or other p		- 1	20c. Location -		
ゴame Baltimore, N			4 □ Donation 5 □ Other (Specification    4 □ Donation 5 □ Other (Specification    5 □		Baltin	ore Cremat		10.00		2311	aryland
D #	permit. Departr Importe any Inju		21. Signature of Funeral Service Licer	\$66		22. Name and Add					al Home, Inc
	40 F # 9		1 Muchily	hon		14/ Duke	of Glouces	ter St.	Annapo	olis,	MD 21401
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	death. Do	not enter the mode of d	ying, such as cardiac o	or respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final		JUN (10	arx Ar	tery di.	10010			Onset and Death
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Box 6	certif ding ise a	Physician/Me	IF FEMALE:	23c. If yes, outcome of p	pregnancy				22d Dat	te of deliver	
B	atter for u	ä	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 C		3 ☐ Ectopic pregnar 5 ☐ Other (specify)					Day Year
P.O.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	o or gouth	J Cities (Specify)					
۵.	that t		Part II. Other significant conditions of	ontributing to death but n	ot resulting i	n the underlying cause of	given in Part I.	23e, Did tob	acco use confi	ribute to the	e cause of death?
15,	signe signe bed	þ	•			the disconjung dades	g.vo v		s 2□No	3 ☐ Proba	
o c	requ een Joulk	tec						, , , ,			
ec	law las b	ğ						24a. Was an autops perform	1 24b. \	Nere autop	psy findings available inpletion of cause of
-	The ete r	Completed						perform 1 ☐ Yes 2	ned?	death? I∐Yes 2	
Division of Vital Records,	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Be	25. Was case referred to medical examiner?				26. Place of Death				
>	ysic dire	10	1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ERVOL	tpatient 3 DOA	Other: 4 Nursing Ho	me 5 Reside	nce 6 □Oth	er (Specify,	)
0	g Pr		27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b.	Time of 28c. In njury W		28d. Describe ho			
<u>.</u>	ndin ath. e fur A	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		, ,		☐Yes 2☐No				
<u>×</u>	Atte	Certification:	3 Suicide 6 Could not be determined	286. Place of injury	- Al home, fa	ım, street, faclory, offic	e :	28f. Location (Str	reet and Numb	er or Rural	Route Number,
á	after after din	ert	4   Hollicide	building, etc. (	эр <b>ө</b> спу)			City or Town	, State)		
	spite nours nore		29a. Certifier 1 Certifying Ph	ysician: To the best of m	ny knowledge	e, death occurred at the	time, date and place,	and due to the ca	use(s) and ma	nner as sta	ated.
	24 h 24 h Fu	Medical	(Check only 2 Medical Examone)	niner: On the basis of ex- and manner stated	amination an	d/or investigation, in my	y opinion, death occurr	ed at the time, da	ite and place,	and due to	the cause(s)
	o th o th ompl	Me	29b. Signature and title of certifier	0.1		29c. Lice	nse number	25	d. Date signed	(Month, E	Day, Year)
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	,5		12 060 1010		- //		) / 0 / /		10702	/	1, 2006 Angulis
	13		30. Name and address of person who	completed cause of death	(Item 23a)	1 - 22	Hill	( + ·	-+- >		1
			21 Date filed (15 th Co. V. and	J. / 1	17 9	135	7,7775	-1 5	1110	/ /	Angrilis
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	aignature	1					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 11:15 A M Herbert D. Rowell, Jr. August 06 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 5926 Sneed Drive Deale Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 14, 1 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1941North Carolina 1 1 M M 2 □ F Director 65 242-54-7100 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ir then "netural", or items 23a or 28a-f show the Wedical Examinar must be notified at 1 ☐ Yes 2 X No Director Marvland | Anne Arundel Deale 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 5926 Sneed Drive 20751 death v Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Heelth and Mental Hygiene. Int: If Item 27 Is marked other then "netural", or Iter 1 X Yes 2 □ No
If Yes, Give
Year or Dates: 1961-63 1 ☐ Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Herbert D. Rowell, Sr. Claire Blue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne M. Rowell/Wife 5926 Sneed Drive, Deale, Maryland 20751 other 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State August 9,2006 cemetery, crematory or other place) 5 1 ☐ Burial 2 🛎 Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory rematory Edvewater Maryland
22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee 2973 Solomons Island Rd., Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Dancreatic **Physician** 70 MOS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only of e Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural Accident 5 Pending 1 Tes 2 No within 24 hours after death. To the Funeral Director: A investigation 3 Suicide 6 Could not be determined 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) filled in by 4 🗌 Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00059173 Cementer 30. Name and address of person who completed death (Item 23a) (Type Print) Dr. Kathleen Kemmer, M.D. 31. Date filed (Month, Day Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day August 6, 2006 **Physician** Martin Rudolph Smith 8:55 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 79 George Street Carroll Taneytown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug 11, 1927 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 11⊠M 2□F 219-20-0669 78 Yrs. Director Maryland Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at Carroll Taneytown 1 Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21787 79 George Street USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2. No Specify: white Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) College Electrician/Maintenance othar t 7 is markad othar traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be fill out of Health and Mental Hit: If item 27 is marked oth y or other traumatic eventy Mable Virginia Martin Roy Franklin Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred M. Smith, wife 79 George Street, Taneytown, MD 21787 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if itel
any injury or ott 08/08 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State South Carroll Crematory Winfield, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) THROWIC OBSTRUCTUR PUMMANY **Physician** o4eAn /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical as the l attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy o in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. detached the 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform certificate 2 No 1 ☐ Yes 2 ☐ No 1 🗌 Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir this 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) by 4 | Homicide within 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) WJL 8 000 6 Jan. 111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21157 6 THOMAS GAWW STONER AVENUE WESTMIN STER TILMO 2911

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

AUG 1 0 2006

32. Registrar's Signature

#### 06-05996

Edwin Joseph Sinclair

#### Please Type or Print in Black Indelible Ink

State of Maryland /	Department of	Health and	Mental	Hygiene

		- For State Registrar		Certifica	ate of Dea	th			Reg. No.	20	nc 3701
Physicia	ın/	Decedent's Name (First, Middle)						2. Date of De Month	Day	Year	3. Time of Death 0235 hrs
Medical Examir		Edwin 4a. Facility Name (if not institution	Joseph	-	Sinc1	air Town, or Lo	ocation of D	August 1		ounty of De	
	Н	Rt 24 North of Grier R				est Hill				ford	
Funeral		5. Social Security Number	6. Sex 7. Age (In	n yrs. last birt		der 1 Year	If Under 2	1.6.		For	Birthplace (State or eign
Director	12	218-70-8729	1 X M 2 F	50	Yrs.	ths Days	Hours	Min. 03/2	4/1956		Country) Mary land
any	-	Usual Residence of Decedent  10a. State 10b. County	(10)	c. City, Town	or Location						10d. Inside City Limits
<b>*</b> "		MD Wicom		·	sbury						1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number				ip Code			10g. Citizer		•
the Man 2 3 a or 2 otified		1832 Mt. Herma	n Road			218	04			US	Α
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status  1 Never Married 2 M	12. Was Decedent Eve arried Armed Forces?	er in U.S.				( Specify Yes or I uerto Rican, etc.)	No- 14	. Race - Am White, etc	nerican Indian, Black,
ter dea			1 Yes 2 X	No	1 Yes	2y No	specify:		Sp	ecify:	White
ours af	d b	15. Decedent's Education (Spe	or Dates:	ted) 16a.	Decedent's Usua	il Occupatio	on (Give kind			d of Busines	ss/Industry
6 172 ho an "ns	Completed	Elementary/Secondary (0-12)			during most of w	orking life, L	JU NUT USE	e reurea)			
003 within giene.	E	12 17. Father's Name (First, Middle	none	Pa	ainter	11	R Mother's N	lame (First, Middle			rovement
21215-0036 ruld be filed within 7 Mental Hygiene. marked other than cevent, the Medical	Bec	Edwin Barton S						thy Ruth			
21; ould b d Men s mar	일	19a. Informant's Name/Relations	ship (Type, Print)			•	and Numbe	r or Rural Route N	umber, City	or Town, St	
MD nd 2 sho afth and m 27 is		Edwin B. Sinc	Lair/father		.2531 Pa			ch Road,			Anne, MD 2185 or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Melical Examiner must be notified at once		20a. Method of Disposition  1 Burial 2 Cremation	n 3 Removal from State	cremat	tory or other plac	e)		Date		ĺ	
Itim it. Pag rtment ortant: y or o	$\neg$	4 Donation 5 Other S	DCONY.	Sincla	ir Fami	-	10	/17/2006	Pri	ncess	Anne, MD
Ba perm Depa Impo		amon X/VII	Marx MOO	205	Hinmar	ı Fune	ral H	ome ve Pri	00000	Anna	MD 21853
Physician		23a. Part I. Enter the disease, of failure. List only one cause	complications that caused the								Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease	a. Multiple Injuries								Death
		or condition resulting in death)	Due to (or as a consequ	ence of):							
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	ence of):							
	Examiner	(Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequ	ence of):							
cecuted	Ê		d								
<u>a a a</u>	ledical	UNPENDED	AMENDED								
	ا≩	IF FEMALE: 23b. Was decedent pregnant in t	he 23c. If yes, outcome to 1 Live birth		2 Fetal deat	h 3	Ectopic pr	egnancy		Date of delivionth	very Day <b>Y</b> ear
Box 687 ne death certification in the attending red for use as t	sicia	past 12 months?  1 Yes 2 No 9 Un	4 Pregnant at tim	f	5 Other (Sp						
b. Bc the dea by the a	Physician	Part II. Other significant condi	9 ONKHOWN	ut not resultin	a in the underlyi	ng cause giv	ven in Part I	. 23e. Did	tobacco us	e contribute	to the cause of death?
s, P.O. ires that the signed by t	þ				,	3 0			res 2 🗸	No 3 F	Probably 4 Unknown
ords, w requir s been s should 1	eted							24a. Wa	as an copsy		autopsy findings available to completion of cause of
Recol The law icate has	dmo							pe	formed?	death	1?
Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been is led in by the funeral director, page 2 should 1	ပ္	25. Was case referred to medica	al					neck only one)			
Vita hysici r this c	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient		Outpatient 3	DOM:		lursing Home 5		e 6 🗸 Ot	her: Scene
n of Vil ding Physic h. After this		27. Manner of Death  1 Natural 5 Pen	28a. Date of Injury (Month, Day, Year ding FOUND:	) 28b.	Time of Injury JND:	28c. Injury	at Work? es 2 ✔ No	28d. Describ			ollision
ivisior or Attencather death Director:	icati	2 🗸 Accident Inve	estigation Aug 13, 2006		5 hrs_ arm, street, facto				(Street and	Number or	Rural Route Number, City
Divis spital or A hours after ineral Dire	Certification;		ormined (Specify) Major				•	or Town Rt. 24 No		er Nurser	y Road, , MD
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending completely filled in by the funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier 1 Certifying P	hysician: To the best of my ki								
To will	Me	29b. Signature and title of certifi	and manner stated.		2	gc. License	number		29d. Da	te signed (i	Month, Day, Year)
		anes				O.C.N	1.E.		Augu	st 13, 20	06
		30. Name and address of person Ana Rubio MD. As	n who completed cause of dear sistant Medical Examin		Penn Street,	Baltimor	re, MD 2	1201			
		31. Date filed (Month, Day, Year)	32. Rygistrar's		1					-	-
Regis	irar	HUU I 3	LUUU MANA	1	Spelle						

			1 - For State Registrar		State of			artmen	t of H		and M	lental Hyg	giene	2006	5 2704
			Decedent's Name (First, Middle)	fle, Last	)							2. Date of Dea	ath		3. Time of Death
	Physici /Medio Examin	cal	Margaret A. S			nber)		4b. City,	Town, o	r Location of	of Death	Month 8	11 4c. 0	Year 2006 County of Dea	12:25 A <sup>M</sup>
	Exami	iei	8315 Whiton R	_				Q.	now	น 11			1	Vorces	ter
	Funeral		5. Social Security Number	6. Se		7. Age (In yrs	. last birthday)	If Under	1 Year	If Under		8. Date of Birtl (Month, Day			thplace (State or Foreign ountry)
	Director		203-42-9206	1 [	M 2000F	53	Yrs.	Months	Days	Hours	Min.	1/15/			PA
	p.		Usual Residence of Decedent			10- 0									404 1-14-01-1-1-1-
	anylar ehov	_	10a. State 10b. Count	У		100.0	ity, Town or Lo	cation							10d. Inside City Limits 1 Tyes 2 XNo
	Ba-f	Director		cest	er		Snow I								
	ith th	Dire	10e. Street and Number					10f. Zip	Code				10g. Citiz	en of What C	ountry?
	filed within 72 hours after deeth with the Maryland Hygiene. other than 'naturel', or itema 23a or 28a-f ehow ent, it e Medical Examinar must be molified at	Ta .	8315 Whiton Rd							863			USA		
	tement in the management of th	Funeral	11. Marital Status		12. Was Dece Armed For	ces?	J.S. 13.	Was Dece II Yes, spe	dent of H cify Cuba	ispanic Ori in, Mexicar	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	1	<ol> <li>Race - Ame Black, Whi</li> </ol>	
36	s afte	by F	1 X Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce		1 ☐ Yes If Yes, Give	9		1 🗆 Yes	2 <b>⊠</b> No	Specify:				Specify: T	White
21215-0036	hour	De p	15. Decede		Year or Da	nes.	16a. Dece	dont's Heu	al Occur	ation			16h Kin	d of Business	
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an	d be antal	00	Charles P	<b>C1</b>	ank					Uo1	on D	rapcho			
Maryland	shoul of Me mark	၉	19a. Informant's Name/Relation				19b. Mailir	ng Address	(Street			i Route Numbe	r, City or	Town, State,	Zip Code)
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no n	ages ont of t: If I		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (		Removal from S		cemetery, crer	-			0 / 1 1	12000	77	1.0	1 - DE
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			Part1. Enter the discusse, shock, or heart fulure is immediate Cause (Final	t only or	ne cause on ea	ach line.									Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		a	Met		tic	15	rea	st	Car	CIN	ema_	072106
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	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	≺	,		, -,								
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Вох	certi nding use a	N/W	IF FEMALE: 23b. Was decedent pregnant	2	3c. If yes, outo								23	d. Date of de	livery
ă	atte d for	ciai	in the past 12 months?			irth 2 ☐ Fet ant at time ol		Ectopic p		<u> </u>				Month	Day Year
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σ.	The law requires thet the death certifica tie has been signed by the atlending ph age 2 should be detached for use as th		Part II. Other significant condi	ions cor	ntributing to de	ath but not re	sulting in the u	nderlying o	ause giv	en in Part I		23e. Did to	bacco us	e contribute t	o the cause of death?
Records,	uires n sign	d by				N	A					1 🗆 Y	es a	No 3□P	robably 4 Unknown
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Re	The lav	Ę										autop	sy med?	prior to death?	completion of cause of
			25. Was case relerred to medic	01						00.01			a No	1 ☐ Yes	s 2□No
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o	Phys raldi	. To	27. Manner of Death		28a. Date o		ER/Outpatier 28b. Time of		28c. Injur	4 📋 NU	rsing Hor	28d. Describe h		Other (Spe	ecity)
O	ding F th. After funera	tior	1₁ Natural 5 ☐ Pend 2 ☐ Accident inves	ing tigation	(Monti	h, Day Year)	Injury	м	Wor	k? Yes 2⊟			. ,		
Division	Attending or death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could		28e, Place	of Injury - At I	nome, farm, str	eet, factor	v. office			281. Location (S	Street and	Number or R	ural Route Number,
S	efter Olre	Certification:	4 Homicide	·	buildin	ng, etc. (Spec	ify)	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Tow	m, State)		
	To the Hoepital or Attending Physician: Within 24 hours effer death. To the Funerel Director Affer this certific completely filled in by the funeral director.		29a. Certifier Cartify	ing Phy	sician: To the	best of my kr	owledge, deati	h occurred	at the tin	ne, date an	id place.	and due to the o	cause(s) a	nd manner a	s stated.
	24 h 24 h Fui	Medical	(Check only 2 Madics one)	I Exami	nar: On the ba and mann	sis of examin er stated.	ation and/or in	vestigation	, in my o	pinion, dea	th occurr	ed at the time, o	date and	lace, and du	s stated, e to the cause(s)
	ompl	Me	29b. Signature and title of certif	er A				29	c. Licens	e number			29d. Date	signed (Mon	th, Day, Year)
	->F0		16 h	1)/1	11		-		W	000	565	241	09	_11_	76
			30. Name and address of perso	Who ra	mpleted cause	e of death (Ita	m 23a) (Type	Print)	- 1 (		70'		00	(1)	0
RA	10		IDULE A	100	n ( )	RI	d Ro	ما الم	11		D	ehoro	ah	Coni	ran, Do
	Sta	ite	31. Date filed (Month, Day, Yea AUG 1	r)	32.	gistrar's Sign	nature	1 4	-						
	Registi		AUG 1	4 2	JUB 4	and a	NA	and:							

06-06026 Sandra Smith

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Control of Pleating and Wentaring Certificate of Death	Reg. No.
Physic edical Exan		1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year August 13, 2006  3 Time of Death 2240 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Lake Churchill - Wynnfield Drive @ Laure Germantown	
Funera		5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr.	8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Directo		212-90-1094 1 M 2XF 44 Yrs Months Days Hours Mir	SEPT 16 196 Country MD
w any		10a. State 10b. County 10c. City, Town or Location POOLESVILLE	10d. Inside City Limits 1 X Yes 2 No
aryland 8a-f sho	Director	10e. Street and Number 10f. Zip Code	1 Yes 2 No
ith the Maryland 23a or 28a-f show any notified at once.	Dire	17209 GENERAL CUSTER WAY 20837	USA
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is amarked other than "natural", or items 23a or 28a-f sho and one the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.) White, etc.
irs after tural", o	l yd	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	
21215-0036 hould be filed within 72 hours after of Mental Hygiene, is marked other than "natural", if event the Medical Evanimer.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  1 2 during most of working life. DO NOT use ref HOUSEWIFE	DOMESTIC
21215-0036 suld be filed within 7 Mental Hygiene marked other than	S S	17 Father's Name (First, Middle, Last) 18.Mother's Name	e (First, Middle, Malden Surname)  JONES
2121 ulld be fi Mental   nıarked	o Be	19a Informant's Name/Relationship (Type, Print ) 19b Mailing Address (Street and Number or	Rural Route Number, City or Town, State, Zip Code)
ore, MD Set I and 2 show of Health and If item 27 is the I from marin		RICHARD SMITH / SPOUSE 17209 GENERAL CUST  20a Method of Disposition (Name of cemetery)	TER WAY, POOLESVILLE, MD  Date   20c. Location - City or Town, State
Baltimore, MD 2 permit Pages I and 2 shou Department of Health and Minportant. If itiem 27 is a ministry or other trainmatic		1 Burial 2 Cremation 3 Removal from State MONOCACY CEMETERY 8/	
Baltimo permit Page Department of Important:		21. Signature of Funeral Service Licensee  22. Name and Address of Facility FUNERAL PLO BOX 86, BZ	HOME ARNESVILLE, MD 20838
Physicia	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	
/Medica Examine		Immediate Cause (Final disease or condition resulting in death)  Drowning  Due to (or as a consequence of):	Death
	ā	Sequentially list conditions, if any, leading to immediate b	
	Examiner	cause. Enter Underlying Cause (Cinegas or injury that initiated events resulting in death). Last  Due to (or as a consequence of):	
xecuted n and		d AMENDED	
760, icate be execut physician and the burial - tran	≥	ITEMFZ3a,Z/,Z8a=I,PENYL,g838,8/31/U0  IF FEMALE: 23c. If yes, outcome of pregnancy	TT 23d Date of delivery
x 68 th certifi	Physician	23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of death 5 Other (Specify)	ancy Month Day Year
P.O. Box 68': that the death certifi- med by the attending	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?
_ s			1 Yes 2 No 3 Probably 4 Unknown  24a Was an 24b. Were autopsy findings available
tal Records tian: The law requi certificate has been	1 2		autopsy prior to completion of cause of performed?
Vital Recysician: The his certificate his director page	Be Co	25. Was case referred to medical examiner? Hospital. 4 Postiont 3 FR/Outstingt 3 Post Other Number	1 Yes 2 No 1 Yes 2 No sonly one)
Division of Vital Records, Hospital or Attending Physician: The law requir 24 hours after death Funeral Director: After this certificate has been s	-	examiner?  1 Ves 2 No Hospital. 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursi  27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?	ng Home 5 Residence 6 ✔ Other: Scene  28d. Describe how injury occurred
Division tal or Attendir rs after death al Director:	Cation	Pending   S/13/2006   Fnd 8:07 pm   1 Yes 2 X No	subject drowned
Division Hospital or Attence 24 hours after death Funeral Director:	Certification	3 Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc.  (Specify) Lake	28f. Location (Street and Number or Rural Route Number, City or Town, State Wynnfield Grove @ Laurel Hill Way Germantown, MD
the the	Medical	29a Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	
To To	Mec	and manner stated.  29b Signature and title of certifier  29c. License number	29d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)	August 14, 2006
		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201
Regi	State istra		

			State of Maryland / Department of Heal  1 - State Registrar Certificate of Deal		ental Hygien Rag. N	4000	27043
Ì	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Charles Robert Stup		2. Date of Death August 20	<sup>рау</sup> 200б <sup>өөг</sup>	3. Time of Death 7:25 PM M
•	Examin		4a. Fecility Name (If not institution, give street and number)  Homewood at Crumland Farms  4b. City, Town, or Local Frederi	ation of Death .ck	4	c. County of Death Frederic	Ċ
	Funeral Director			Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Yea 10-14-19		place (State or Foreign intry)
	Du A		Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryi -f sho	to	MD Frederick Frederick				1 ☐ Yes 2 No
	r 28a	lrec	10e. Street and Number 10f. Zip Code		10g. C	Citizen of What Cou	intry?
	23a c	alD	7401 Willow Road 21702			USA	
950	permit. Pages 1 and 2 should be lited within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Beginnerant if time X7 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic avant, the Medical Extratraction and the notified a pone.	by Funeral Director	11. Marital Status  1	nic Origin? (Spe exican, Puerto I pecify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
֝֝֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	72 hou natura		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	g most of worki	16b.	Kind of Business/I	
7	within ane. then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 4 U.S. Government		-	ccountant	
א ב	Hygid other	BeCc			(First, Middle, Maide		
<u>a</u>	uld be Wenta Irkad Itic av	To B	Charles William Stup Ad	die Est	ell Fagan		
a J	and I ma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and N				p Code)
ב ב	1 and Health am 27 ther to		Susan Jenny Boyer Daughter 5503 Coral Aven  20a. Method of Disposition  20b. Place of Disposition (Name of commetery, crematory or other place)	-	-	Location - City or 1	own, State
	Pages ent of nt; If it ry or o		1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  ### Coliet Cemetery	8/22/		ederick.	·
Dallillo	permit. Depertm importa any inju		21. Signature of Funeral Service Licensee  John Co Kan M01176  22. Name and Address of Keeney and E 106 East Chu	Facility Basford	PA Funera	1 Home	
			23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su	ch as cardiac o	r respiratory arrest,		Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition resulting in death)  a. Atheroseler of	ic He	enit D'	SEASE	Onset and Death
1	/Medical Examiner		Due to (or as a consequence or):	,			1.
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
	ficate be executed physician and is the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
00/0	e be e /sician e buria	dical	d				
	rifficat ng phy as the		IF FEMALE:				
.O. DOX	The law requires that the death certific site has been signed by the ettending p page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unknown  23c. If yes, outcome of pregnancy 1  Live birth 2  Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5  Other (specify)			23d. Date of deli- Month	very Day Year
Corus, r	urres that signed b lid be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I.	23e. Did tobacco		the cause of death?
Doan	The law rec te has beer age 2 shou	Completed	Atrial Fibellation		24a. Was an autopsy performed?	prior to c death?	opsy findings available ompletion of cause of
<u> </u>	artifice ctor, p	BeC	25. Was case referred to medical examiner?	Place of Death	(Check only one)	10 103	2 140
5	hysic this ce at dire	၉	1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA		me 5 Residence		rfy)
5	nding f ath. r: After e funer	atlon:	27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?  2 Accident investigation  28a. Date of Injury  28b. Time of Injury  48c. Injury at Work?  1 Yes		28d. Describe how in	jury occurred	
NIN I	ai or Atta s after de ai Diracto ad in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	28f. Location (Street and City or Town, Sta	and Number or Rui ite)	ral Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier (Check only one)  Cartifying Physician: To the best of my knowledge, death occurred at the time, de	ate and place, a n, death occurre	and due to the cause ed at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	withi To t	W	29b. Signature and title of certifier  29c. License nun  D16428	mber		pate signed (Month	
	(n		30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print)			,	
	17		Casper E. Cline III MD 300 West Ninth Street Fr	ederick	, MD 2170	1	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 5 2006 32 Registrar's Signature				

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Reg. No.	1006 2/044
		1. Decedent's Name (First, Middle, Last)	2. Date of Deeth Month Day	3. Time of Death
	Physician /Medical	Lucille C Tonkins	8-9-2006	
	Examiner	4a Facility Name (If not institution, give street end number)  4b. City, Town, or Loc	ation of Death 4c.	County of Death
		11933 Autumnwood lane Ft Washing		ince Grorge's
	Funeral		8. Date of Birth (Month, Day, Year)	Birthplece (State or Foreign Country)
	Director	577-24-5888 1 M 2LXF 86 Yrs. Usuel Residence of Decedent	5-15-1920	) Maryland
	pu &	10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Maryl f sho	Md Prince George's Ft Washington		1⊠ Yes 2□ No
	the notific	10e. Street end Number 10f. Zip Code	10g. Citi	zen of Whet Country?
	3a or	11933 Autumnwood Lane 20744	τ	JSA
	uter death with the Mai r tems 23s or 28s-f s niver must be notified Funeral Director	11 Marital Status 12, Was Decedent Ever in U.S. 13, Was Decedent of Hispanic Origin? (Spec	cify Yes or No-	14. Race - American Indian, Black, Whita, etc.
21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "retural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Evantivat must be notified at once.  To Be Completed by Funeral Director	Armed Forces? If Yes, specify Cuben, Mexican, Puerto R  1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 □ Yas 2 □ No Specify:  3 □ Widowed 4 □ Divorced Yeer or Dates:		Specify: Black
Ą	2 ho	15. Decedent's Education 16a. Decedent's Usual Occupation  (Give kind of work done during most of working	16b. Ki	nd of Business/Industry
21,5	ed within 72 ho ygiene. Wr then "natura it, the Medical I	(Specify only highest grade completed)  [Give kind of work done during most of workin, life. DO NOT use retired)  [Give kind of work done during most of workin, life. DO NOT use retired)		111 6
2	Son the control of th	9th Practicle Nurse		lth Care
P	Be (Be (Be (Be (Be (Be (Be (Be (Be (Be (	17. Fether's Name (First, Middle, Last)  18. Mother's Name  Unknown  Edna V	(First, Middle, Maiden	Surname)
<u>Xa</u>	Ment Ment Ment Ment Ment Ment Ment Ment			
Maryland	2 shd end fs m	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rurel		
<b>~</b>	leadth m 27 m 27 her t	Wayne A Tonkins, ESQ, Son 11933 Autumnwood Ln  20a Method of Disposition (Neme of		ngton Ma 20744 cation - City or Town, State
0	ges i	1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State	2006	
Baltimore,	t. Pa tmen tant: ijury			dover, Md
Bal	permit Depar Impor any In	21. Signature of Funefal Service Censee 22. Name and Address of Facility Tay		
	40144	1722 North Capita		
	-	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest,	Approximate Intervel Between Onset and Death
	Physician /Medical	Immediate Cause (Final		
- 1	Examiner	disease or condition resulting in death)  a. CONGESTIVE CARINO MYS	PATHY	
		Due to (or as a consequence of):		
	min min	b. ADVANCED DEMENTIA  Due to (or as e consequence of):		
Ć.	Attending Physician: The law requires their the death certificate be executed as death.  ector: After this certificate has been signed by the attending physician end by the funeral director, page 2 should be datached for use as the burial-trensit this funeral treatment of the partial physician/Medical Examiner iffication: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c.		
68760,	ficate be physicials the burns the burns edical	that initiated events Due to (or as a consequence of):		
	ng ph es th	resulting in death) Last		
Вох	eath cer attendir I for use Iclan/A	d		
	aw requires their the death censished by the attending should be datached for use pleeted by Physician/I	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco	use contribute to the cause of death?
P.O.	et the		1 Tes 2	No 3 Probably 4 Unknown
<u>ග</u>	as the igner be d			Odb. Many automorphisms
oro	een s		24a. Was an autor performed?	24b. Were autopsy findings aveilable prior to completion of cause
ec	law las b e 2 sl			of death?
<u>=</u>	Physician: The law requires the this certificate has been signed at director, page 2 should be of a To Be Completed by		1 ☐ Yes 2	No 1 □ Yes 2 □ No
<u> </u>	clan: extific ector	25. Was case referred to medical examiner?  Hospital: 4 Classical Conference of Death		
of	this of all directions.	1 Tes 2 No 1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Horr	Residence	
E C	Affer funer funer	1 Natural 5 Pending (Month, Dey Year) Injury Work?	og. Dooring from injur	y 00001100
Sic	death death stor: y the	2 Accident 3 Suicide 6 Could not be 20 St. (1.1) At the stand feeten efficiency	8f. Location (Street an	d Number or Rurel Route Number,
Division of Vital Records,	Lal or Attending Presents death.  In Director: After the in by the funers  Certification:	4 Homicide determined 286. Place of Injury - At nome, tarm, street, factory, office building, etc. (Specify)	City or Town, State	)
_	To the Hospital or Attending Physician: Tha is within 24 hours effer death.  To the Funeral Director: Affer this certificate ha completely filled in by the funeral director, pege Medical Certification: To Be Com	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	nd due to the cause(s)	and manner as stated.
	he Hospit in 24 hour he Funera pletely fill edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurre one)	ed at the time, date and	I place, and due to the cause(s)
	Nithin Fo th Comp	29b. Signature and title of certifier 29c. License number	29d. Da	te signed (Month, Dey, Year)
		D-27660	8	11/06
. 1	(8)	30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)		
K	0	Alpana Goswami, MD 11119 Rockville Pike #G1	00	
'	State	31. Date filed (Month, Day, Year) 82. Registrer's Signeture.		
	Registrar	AUG 1 1 2006 Block & Space		
	0411.44 D			

DHMH 16 Rev 6/95

**ORIGINAL** 

		•	For State Registrer	State of Marylan		epartment of H Certificate of I			gien Reg. No	21116	27045
			1. Decedent's Name (First, Middle, Last	)				2. Date of De Month	ath Da	ay Yeer	3. Time of Death
	Physicia /Medic	_	Elizabeth Al	verta Tyle	r			August		2006	9:15p M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat	h	40	c. County of Deat	h
			10010 Goldenwoo	od Court		4 4	Marlboro			Prince G	
	Funeral		5. Social Security Number 6. Se	TM 20XIE		Months Days	If Under 24 Hrs Hours Min.	(Month, Da	th ly, Year	9. Birtl	hplace (State or Foreign untry)
	Director		579-18-1812 Usual Residence of Decedent	95	· ·	rs.		May 28	, 19	911   Pen	nsylvania
	and w	1	10a. State 10b. County	10c. Cit	y, Town	or Location					10d. Inside City Limits
	Mary i eho	ō	Maryland Prince (	Coorce Unp	or N	far1boro					V∑Yes 2 No
	28a	Je C	Maryland Prince ( 10e. Street and Number	eorge topp	er r	10f. Zip Code			10g. C	itizen of What Co	untry?
	3e or	≘	10010 Goldenwood	Court		20772			Uni	ted Stat	es
	deetl	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Drigin? (S	Specify Yes or No	)-	14. Race - Ame Black, White	
٥	n 72 hours alter death with the Maryland "natural", or iteme 23e or 28e-f ehow Wiral Examirat must be notilised at		1 Never Married 2 Married	1 ☐ Yes 2 📉 No		1 ☐ Yes 2X No	Specify:	to rican, etc.,			•
5-0036	ours ral',	d by	3 Widowed 4 □ Divorced	Year or Dates:						Specify: Bla	
ည်	72 h	Completed	15. Decedent's Edu (Specify only highest grad	ucation le <i>completed)</i>	(	Decedent's Usual Occup Give kind of work done	during most of wo	rking	16b. i	Kind of Business/	Industry
2	within 72 ene. than "nai	ם	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retired	•		C	overnmen	+
N	The second second		12 17. Father's Name (First, Middle, Last)	+4	Re	egistered N		me (First, Middle			. L
ä	ntal ad c	Be C	Joseph Benjamin	Buttler					Wall		
Maryiand	should I nd Men marka umatic	ဠ	19a. Informant's Name/Relationship (T		19b.	Mailing Address (Street					Zip Code)
εο <b>Ξ</b>	ss 1 end 2 should of Health and Mei item 27 ie mark r other treumstic		Charmayne Tyler-Jac	ckson/Daughter	100	010 Goldenw	ood Cour	t Upper	Mar	lboro, M	d. 20772
<u>6</u>	S 1 er		20a. Method of Disposition	۱ ,	lace of I	Disposition (Name of , crematory or other place	-01	Date	20c. L	ocation - City or	Town, State
Ë	Page ent o nt: If ry or		1 Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,	demoval from State		incoln Ceme	. 1	2-06	Bre	ntwood,	Maryland
altimore,	permit. Pages Depertment of I Important: If its any injury or or once.		21. Signature of Funeral Service Licens			22. Name and Addre	ss of Facility				•
ñ	20 = 3		Trithal	aux 5/010	85	Pope Fune 5538 Marl	boro Pik	e Forest	vi1	le, Md.	20747
			23a. Part1: Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deat	h. Do no	ot enter the mode of dyin	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Physician	8 7	Immediate Cause (Final disease or condition	. Dementia							Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	uence of	n:					
	Examiner		Sequentially list conditions.	<sub>b.</sub> Generalized							
	D #	iner	Sequentially list conditions, if any, leading to immediate cause the conditions of the cause (Disease or injury	Due to (or as a conseq	uence of	i):					
	ecute end tran	Examiner	that initiated events resulting in death) Last	c.  Due to (or as a conseq	uanca of	n-					
9	icate be executed physicien end s the burial-transit	a E		540 (0 (0) 45 4 55) 554	001100 01	· /·					
98760	icate phys s the	edicai		d.							
_	ding	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy					23d. Date of del	iverv
Rox	death	clar	in the past 12 months?	1 Live birth 2 ☐ Feta 4 Pregnant at time of d		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	<i>'</i>			Month	Day Year
a.	res that the de signed by the e be detached t	Physician/M	9 ☐ Unknown	9□ Unknown							
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions co	ntributing to death but not res	ulting in	the underlying cause giv	en in Part I.	23e. Did	obacco	use contribute to	the cause of death?
ğ	w require been sig should b							1 🗆	Yes 2	2□No 3□Pr	obably 4 Unknown
Vital Records,	aw re as be 2 sho	Completed						24a. Was		24b. Were au	itopsy findings available
ř	The I	mo:						perfo	ormed?	death?	2□ No
<u>ta</u>	hysician: The la his certificete has I director, page 2	Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only	585		
<u>&gt;</u>	hysic this ce al dire	2	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outp		4 🗀 ivursing i			6 □Dther (Spec	cify)
Division of	Attending Physician: It death.  ector: Alter this certification by the funeral director.	:00	27. Manner of Death 1. XXIII atural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Ti	jury Wor		28d. Describe	how infi	ury occurred	
Sid	tend leath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	100/1		111	
$\leq$	를 들는 를	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, fari y)	m, street, factory, office		City or To	wn, Sta	ina Number or Hu te)	ural Route Number,
_	Hospital 24 hours a Funarel I tely lilled		29a. Certifier 1 Certifying Phy	sician: To the best of my kno	wiedre	death occurred at the tir	ne date and place	e and due to the	cause/	s) and manner as	stated
	Hospital     24 hours     Funarel     letely lilled	edical	(Check only 2 Medical Examone)	iner: On the basis of examina and manner stated.	ition and	or investigation, in my	pinion, death occ	urred at the time,	date ar	nd place, and due	to the cause(s)
	To the Hospital within 24 hours and To the Funarel completely litled	Me	29b. Signature and title of certifier	0		29c. Licens	e number		29d. D	ate signed (Monti	h, Day, Year)
			1 4	C		DA.	2955		Δ.	ug. 10,	2006
^	(4)		30. Name and address of person who o	completed cause of death (Item	n 23a) (1		_,		A	ug. 10,	
\\^{\cdot}				l Livingston F	load		ington, l	Md.			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	aturo	de					
	Regist	ar	AUG 1 1 2005	hered y	7						

	_ 1	For Amend #8 Per Th W860 10	Certificate of I	Death	R	eg. No.	000	E-10*
Discontact	_	Decedent's Name (First, Middle, Last)			2. Date of Deat Month	Day	Year	3. Time of Death
Physicia /Medic	al _	Mary Helen Todd			August	1	006	6:30a.
Examin	er <sup>4</sup>	ta. Facility Name (If not institution, give street and number)  2575 Toddville Road		r Location of Death Ville		Dor	y of Death chest	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las 1 ☐ M 2 🕅 F 76	t birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar 27,	Year)	9. Birthp Coun Mar	ace (State or Fore try) 1land
a-f show			Town or Location oddville				1	0d. Inside City Lir
3a or 28 I be not	0	10e. Street and Number 2575 Toddville Road	10f. Zip Code 2167	72	1	0g. Citizen of	What Coun	try?
Department of Health and Mental Hygiene. Important: if itsm 27s or 28s-f show Important: If itsm 27 is marked other than "natural; or itsms 27s or 28s-f show say injury or other trsumatic svent, the Medical Exeminar must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1  Yes	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		ace - Americ ack, White, ify: Wh:	etc.
ne. nan "natural n Medical Ex	Completed t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of work	king	16b. Kind of 8		
Hygier other ti	Be Cor	17. Father's Name (First, Middle, Last)	Painter	18. Mother's Nam	e (First, Middle,	Elect Maiden Suma		<u> </u>
i Menta narked natic sv	ToB	Walter McKinley Brittingham	19b. Mailing Address (Street		Mae Fra		n State Zin	Code)
traum		19a. Informant's Name/Relationship (Type, Print)  Barbara A. Willey Daughter	1501 Race Str					
nt of Health a t: if itsm 27 is y or other trs:		20a. Method of Disposition 20b. Pla	ce of Disposition (Name of netery, crematory or other place Veterans Cemet	ce)	Date	20c. Location	- City or To	wn, State
Departme Importen sny injuri once.		21. Signature of Funeral Service Licensee	22. Name and Addre Thomas Fur 700 Locust	ess of Facility	e. P.A.			_
physicien and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that mitiated events resulting in death) Last  b. Due to (or as a consequence of the consequenc						
by the ettending ached for use as	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnant 1 Live birth 2 Fetal c 4 Pregnant at time of dea 9 Unknown	death 3 Ectopic pregnanc	у			Date of deliver	ery Day Year
ed sign	<u>م</u>	Part II. Other significant conditions contributing to death but not result by Pothy Coid SM, Conges	ting in the underlying cause gr	Failure	1 T Y	′es 2⊡No	3 <b>3</b> 000 ot	ne cause of death  ably 4 Unkr
certificete has be rector, page 2 sh	e Completed	Colon Paups, Divertical 7	sland Ane	mla	24a. Was autop perfor 1 Yes	med? 2000	prior to co death? 1 🗌 Yes	mpletion of cause
s after death. al Director: Affer this cer ed in by the funeral direc	ation: To B	27. Manner of Death  1	28b. Time of linjury Wo	ry at	ome 5 PResid			y)
within 24 hours after ded To the Funeral Director completely filled in by th	Certification	a Could not be	ne, farm, street, factory, office		28f. Location (S City or Tow		nber or Aura	al Route Number
n 24 hours a le Funerai i	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	rledge, death occurred at the ti on and/or investigation, in my	ime, date and place opinion, death occu	, and due to the or rred at the time, or	cause(s) and i	manner as s e, and due t	tated. the cause(s)
within 2 To the complet	Me	29b. Signature and title of certifier and a factorial continuer and title of certifier and the continuer and the continu	7.0. 29c. Licen	se number 446/	5	29d. Date s/gr	ned (Month,	Day, Year)
		30. Name and address of person who completed cause of death (Item	23a) (Type Print)			1	1	

			1 - For Amend Item 9	State of Maryley	09713 Ce	7000nbot	f Health a	nd Men	tal Hygi	iene g. No. 200	6 2704
			Decedent's Name (First, Middle, Last)						Date of Death	1	3. Time of Death
	Physicia		Frederick Filmo	re Turner	Tr				Month 1qust	8, 2006	
	/Medic Examin		4a. Facility Name (If not institution, give s		01.	4b. City, Town	n, or Location of		rguse	4c. County of De	
	Examin	er	3190 Woodcox Ro			India	n Head	1		Charle	2.5
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Under 2		ate of Birth Month, Day,	9. E	irthplace (State or Foreign
	Director		217-36-5933	<sup>M 2□ F</sup> 65	Yrs.	Months Da	ys Hours	Min. Ma	month, Day, arch	7,1941 <b>M</b>	ary land
ō			Usual Residence of Decedent								
rylan	how		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
a Z	- deliti	cto	Maryland Charle	s	India	n Head					1 ☐ Yes 2 X No
death with the Maryland	or 28	Directo	10e. Street and Number			10f. Zip Cod	le		10	og. Citizen of What	Country?
- S	23a	a	3190 Woodcox Roa	ıd			0640			U.S.A.	
r dea	E 2	Funeral	11. Marital Status	<ol><li>Was Decedent Ever in U Armed Forces?</li></ol>	.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Orig Cuban, Mexican	in? (Specify Puerto Rica	Yes or No- n, etc.)	14. Race - Ar Black, W	nerican Indian, hite, etc.
o age	2		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 □ Yes 2 □ X1	No Specify:			Specify: T	White
5-0035	"natural", or itama 23a or 28a-f ahow kilical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:							
2 2		Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Oc kind of work do DO NOT use re	ne during most	of working		16b. Kind of Busines	ss/industry
- 12 13- within 72	than than	ם	Elementary/Secondary (0-12)	College (1-4or 5+)			 Constr	uctor	. т	Flevetor	company
N B	Hygie ther nt.	ပို	12 17. Father's Name (First, Middle, Last)		ETE	vacor				faiden Sumame)	Company
Viand	ntal ad o	00	Frederick Filmo	re Turner.	Sr.		Rut		Pos		
. 0	nd Menta markad matic a	၉	19a. Informant's Name/Relationship (Type	<u>.</u>		ng Address (Str	1			City or Town, State	. Zip Code)
Z S	ment of Health and Mental Hygiene. ant: if Itam 27 is marked other than ury or other traumatic avant, tha M		Brenda Turner	Wife		•					id. 20640
ب چ ره	Heal tem ther		20a. Method of Disposition							20c. Location - City	
Pages	ment of ant: If it lury or o		1 Burial 2 Cremation 3 R	emoval from State	cemetery, cre.	matory or other	place) Aug	12,	2006		
Saitimore,	ortan ortan injur		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License				emeter	_		Indian 1	Head, Md.
מ מ	Deperiment of the property of								Home	, P.A.	20640
•			23a. Part1. Enter the disease, or complication of the art failure. List only on	ations that caused the deat	h. Do not en	4270 H	awthor	ne Ro	Diratory arre	ndian He	ead, Md.
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	1	-10 /		N	1	1 - 10	Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	NEHS	7/7	10 F	LING	$C_{j}$	4N C	ER	
	xaminer			Due to (or as a conseq	juence oi):			/			
		e	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):						
per	Insit	Examiner	Cause (Disease or injury								
<b>oU,</b> be executed	sicien and burial-transit	Xa	that initiated events c resulting in death) Last	Due to (or as a consec	uence of):						
	ysicien ne burial	cal	L.								
	g phy as th	_									
. BOX by	ngu nse	cian/Med	IF FEMALE: 23b. Was decedent pregnant 2:	Bc. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		76-4:				23d. Date of	delivery
מַ מַ	d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of c		∃Ectopic pregna ∃ Other (s <i>pecif</i> y				Month	Day Year
2 5	by th	Physi	9 Unknown	9□ Unknown				1			
Ords, T	signed by the attending ph d be detached for use as th	by P	Part II. Other significant conditions con	tributing to death but not res	sulting in the	nderlying cause	given in Part I.	4	23e. Did tob	acco use contribute	to the cause of death?
	been sig	pa	CHRONIC OB	STRUCTIU	EL	LUG	DISEM	52	1 X Ye	s 2 No 3	Probably 4 □Unknown
Hecord The law require	8 8	plet		•					24a. Wasar		autopsy findings available
The law	certificete hes irector, page 2	Completed							autopsy perform	negl? death	o completion of cause of ? es 2□ No
		0	25. Was case referred to medical				26. Place	of Death (Cf	/	V	
- 01	is cell	0	examiner?	ospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA	Other: 4 🗆 Nu	rsing Home	5 Reside	nce 6 □Other (S	pecify)
-		n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		njury at Work?	28d.	Describe ho	w injury occurred	
VISION	death. ctor: All / the fur	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,		1 ☐ Yes 2 ☐ Î	No			
	after deat Diractor: I in by the	111	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, st	reet, factory, off	ice		Location (Str City or Town		Rural Route Number,
5 🖁	s Dire	Certification:									
Hospitalor	within 24 hours after of To the Funeral Direct completely filled in by	cai	(Check only 2 Medical Examin	ician: To the best of my known: On the basis of examina	owledge, deat	h occurred at the	e time, date and ny opinion, deat	d place, and the occurred a	due to the ca	luse(s) and manner ate and place, and c	as stated. fue to the cause(s)
Tothe	within 2 To the complet	Medical	one)	and manner stated.		200 Lie	anno numbor		-10	2d Date signed (Mr	outh Day Your
Ľ.	To To	-	29b. Signature and title of certifier	1		296. Li	ense number	ni	25	9d. Date signed (Mo	Jay, real)
0			1			V)	1070	06		5/11/	06
1	2 11		30. Name and address of person who co	mpleted cause of death (Iter	m 23a) (Type,	Print)	IHR C		, ,		010000
	DID		31. Date filed (Month, Day, Year)	32. Rigistrar's Sign	770 (	740 h	IMR CI	ZHIN	ر کر	ALDORA,	ra 20602
	Sta Registr		AUG 1 4 2	32. Afgistrar's Sign.	H 4	beele					

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Joseph G. Thompson 1. For State Certificate of Death Reg. No Registrar 2 Date of Death Time of Death Decedent's Name (First, Middle, Last) Physician/ Month Day August 10, 2006 1011 hrs **Medical Examiner** Joseph Gervase Thompson, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 21263 Joe Baker Court, Apt. 4D Great Mills 5. Social Security Number 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or **Funeral** oreian Months Davs Hours Director Country) Maryland November 08.1938 215-44-4705 1 XM 67 Usual Residence of Decedent 10d Inside City Limits 10c, City, Town or Location 2 10a State 10b County 1 Yes 2 X No 28a-f shov Lexington Park Maryland Saint Marys with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? notified at 20653 USA 21263 Joe Baker Court Apt. items 23a Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married after death 2 X No Yes f Yes. Give Year Widowed 4 Divorced Yes 2 X No specify. Specify: White "natural" ð 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 sent of Health and Mental Hygiene ant; If item 27 is marked other than 'pr other traumatic event, the Medical Baltimore, MD 21215-0036 Disabled 18 Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Mary Agnes Nelson Joseph Garvase Thompson, Sr. 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20650 Joseph Leonard Thompson, Sr./Brother 24900 Pin Cushion Road Leonardtown, 20b. Place of Disposition (Name of cemetery 20c Location - City or Town, State 20a Method of Disposition Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 08/14/2006 permit Page
Department of
Important:
injury or oth Morganza, MD St. Joseph's Cemetery Other Specify Donation 5 22. Name and Address of Facility nature of Funeral Service Licen Mattingley-Gardiner Funeral Home, P.A. 41590 Fewick Street Leonardtown, MD 20650 t I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last d pue Physician/Medical UNPENDED AMENDED physician : Box 68760 23c If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE. 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Dav Year Fetal death ttending past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. \$ 1 Yes 2 No 3 Probably 4 V Unknown Completed has been s 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate | ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✓ Other: Scene this 1 V Yes 2 After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No 5 Pending death To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated Signature and title of certifie 29d Date signed (Month, Day, Year) 29c License number 29b O.C.M.E. August 11, 2006 30 Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner

State

Registra

(Month Day, Year) AUG I 5

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32. Registrar's Signature

ORIGINAL

			1 - For State Registrar	State of Maryland	•	nent of Health and cate of Death	Reg.		2704
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last     Robert      Aa. Facility Name (If not institution, give     Montgomery Gene	Lee Tobin,	Sr. 4b.	City, Town, or Location of Deat $01 { t ney}$	August 11	year 2006 4c. County of Death	
	Funeral Director		5. Social Security Number 6. Se			Inder 1 Year If Under 24 Hrs hiths Days Hours Min	(Month, Day, Ye		nplace (State or Foreign untry)
	ith the Maryland or 28a-f ehow	Director	10a. State 10b. County  Maryland Howard  10e. Street and Number	Wo	odbine	f. Zip Code	10g.	Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 No untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importent: If Item 27 is marked other than "natural; or Itema 23a or 28a-f show any figury or other traumatic event, Instituted Engin for must be motified at ance.	by Funeral	2940 Duvall Road  11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1956	1 🗆 Y	21797 Decedent of Hispanic Origin? (s specify Cuban, Mexican, Puer es 21XNo Specify:	Specify Yes or No- to Rican, etc.)	U.S.A.  14. Race - Amer Black, White Specify: Wh	ican Indian,
21215-0036	od within 72 ho giene. or than "natu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation de completed)  College (1-4or 5+)	(Give kind i life. DO N	Usual Occupation of work done during most of wo OT use retired) e Officier	rking	. Kind of Business/l	
Maryland	should be file nd Mental Hy marked othu matic event	To Be	17. Father's Name (First, Middle, Last)  Unknown  19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailing Ad	18. Mother's Na Ethel  dress (Street and Number or R		in	ip Code)
	ages 1 and 2 nt of Health a : If Item 27 is or other trac		Robert L. Tobin,  20a. Method of Disposition  1 X Burial 2 Cremation 3 1	20b. Pla cei Removal from State	ice of Disposition metery, cremator,	(Name of or other place)		Location - City or 1	Town, State
Baltimore,	permit. Pa Departmen Importent any Injury		4 Donattee 5 Other (Specify, 21. Signalure of Funeral Service dicens		22. Nar Mo 1 e	ne and Address of Facility Sworth-William Ol Ridge Road	ns P.A., Fu	neral Hom	Kentucky ne 1 20872
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	plications that caused the death.  Due to (or as a consequence)	Do not enter the			Ĵ	Approximate Interval Between Onset and Death
***	Examiner	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	1/	onia				1h-
, 60,	tte be executed tysicien and he burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due o (or as a conseque	ence of):	-bafra			/week
O. Box 68	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnan  1 Live birth 2 Fetal of 4 Pregnant at time of deal 9 Unknown	death 3 □Ecto	pic pregnancy ar (specify)		23d. Date of deliment	very Day Year
S,	w requires that been signed b should be deta	Ď	Part II. Other significant conditions co	ontributing to death but not resul	ting in the underly	ring cause given in Part I.			the cause of death?
Vital Record		Completed					24a. Was an autopsy performed 1 Yes 2	? prior to o	topsy findings available completion of cause of
Division of Vit	ding Ph .r After th funeral	atlon: To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	R/Outpatient 3l 28b. Time of Injury	DOA Other: 4 Nursing   28c. Injury at Work?	Home 5 Residence 28d. Describe how i		rify)
Divis	- e i e -	al Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)			28f. Location (Stree City or Town, S	tate)	
į.	To the Hospitel or within 24 hours after To the Funeral Discompletely filled in	Medical	(Check only 2 Medical Examone)  29b. Signature and title of certifier	iner: On the basis of examination and manner stated.	on and/or investig	ation, in my opinion, death occ 29c. License number	urred at the time, date	and place, and due  Date signed (Month	to the cause(s)
11	ALLA		30. Name and address of person who of	completed cause of death (Item	23a) (Type, Print)	B050410		ugust 12,	2006
	Sta Regist		31. Date filed (Month, Day, Year) AUG 1 4	2006 32. Projistrar's Signatu	& See	Dr Olney M.	-		

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State of Maryland / Department of Health and Mental Hygiene 🗸 🕕 🥼 For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Physician 02145 AM Mary Elizabeth Vaughan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 2718 Bradenbaugh Road White Hall Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🛛 F Hours Yrs. Director 358-26-8755 73 Sept. 8, 1932 Chicago, Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "naturel", or Iteme 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No MD Harford White Hall Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2718 Bradenbaugh Road 21161 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: δ Specify: 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Story Teller/Teacher Performing Arts 4 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth ery liquy or other traumatic event ONG. Franklin S. Rittenhouse Leila Byrne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 2837 Bradenbaugh Road White Hall, MD 21161 Daniel F. Vaughan / Yorktowne Cremation Aug. 19, Service 2006 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) York, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 19 South Main Street Stewartstown, PA 17363 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician a. Overía /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 **X**No 3 ☐ Probably 4 ☐ Unknown Be Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes Hospital or Attending Physicien: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury death. 2 🗆 No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospice, ElkTon, M Far Kas > casons 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 2 5 2006

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death / Month **Physician** 2006 10:15A /Medical 40 County of Death Facility Name (If not institution, give street own, or Location of Death Examiner heverly 9. Birthplace 5. Social Security Number Age (In yrs, last birthday) If Under 1 Year If Under Sex State or Foreign / Funeral Months Days Hours 1 □ M 2 X F 8 28-112 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State or 28a-f show the Medical Examiner must be notified at Yes 2 No Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? or Items 23a 12 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Arican Specify: -Hmerican 3 Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give-kind of work done during most of working life. DD NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "na any injury or other traumatic avent. It a Madic once. College (1-4or 5+) Elementary/Secondary (0-12) Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) iar Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number rooker Place of Disposition (Name of cemetery, crematory or other Method of Disposition - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee P. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lhuthen Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed? res 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 🗌 Inpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification; To 2X ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A death. investigation 2 Accident the Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2006

LITTLE

29b. Signature and title of pertifier

CARY

berson who completed cause of death (Item 23a) (Type, Print)

3001

HOSPITAL

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Marylar		ment of Healt iicate of Dea		tal Hygien	Em U U U	27052
			Decedent's Name (First, Middle, Las	t)		,	2. [	ate of Death		3. Time of Death
	Physici /Medio		Willie 7	Thomas	W:11	iams		ugust Di	10, 2006	1:40 PM
,	Examir Funeral Director		4a. Facility Name (If not institution, give 960 High 5. Social Security Number 6. Security Number 177-56-9621 11	Street	last birthday) II	O. City, Town, or Locate  Camby  Under 1 Year If Ur  onths Days Hou	nder 24 Hz. 8. purs Min	Date of Birth	9. Birth	ester  place (State or Foreign  intry)  NSy [Vania
	pug ≱_		Usual Residence of Decedent  10a, State 10b, County	10c. Ci	ty, Town or Locati	on		1 /		10d. Inside City Limits
	Maryland -f ehow lind at	ō	115	hester	0 1	ridge				1 ØŶes 2 □ No
9	r 28a	irec	10e. Street and Number	7103 101	Carrib	10f. Zip Code		10g. C	itizen of What Cou	untry?
3	23a c	aiD	900 High	Street		2/61	13		USA	
30	rs after death with the Marylan I, or Items 23a or 28a-1 ehow Karchar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ₺ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Ye	Decedent of Hispanic is, specify Cuban, Me Yes 21 No Spe	xican, Puerto Rica	Yes or No- n, etc.)	14. Race - Amer Black, White Specify: Black	, etc.
5	n 72 hours "netural", adical Exa		15. Decedent's Ed	ucation	16a. Decedent	's Usual Occupation		16b. I	(ind of Business/li	ndustry
2	within 7 ene. then 'n	Completed	(Specify only highest grad	College (1-4or 5+)	life. DO	d of work done during NOT use retired)		n	,	,
V	e filed wi al Hygien other th vent, the		10	-	Pro	ep-Coc			e staur	rant
מב	s 1 and 2 should be filed within 72 hours theath and Mental Hygiene. Item 27 is marked other than 'neturel', other traumatic event, I'm Medical Exa	o Be	17. Father's Name (First, Middle, Last)	Nilliams		18. M	Mother's Name (Fir		n Sumame) - NNAN	+
3	shoul nd Me mark umati	၉	19a. Informant's Name/Relationship (T		19b. Mailing A	ddress (Street and Nu	_			•
Ž	and 2 alth a 27 is		Barbara	Mover	900 F	tab Stre	et Car	1bridge	MD.	21613
o	iges 1 a of of Hea or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐		Place of Disposition cemetery, cremate	ny or other place)	Date		ocation - City or T	
	permit. Page Depertment of Importent: if Iny injury or Ince.		4 ☐ Donation 5 ☐ Other (Specify	$M_{i}$	dShor	e Cramatio	N 8/14/	06 Ca.	ubridg	e, MD.
מ	Depermination of the second of		21. Signature of Funeral Service Licens	1 Den	W He	ame and Address of F URY FUNE Washing	eral Ho	Me, P.A.	1 - 11	0 31/13
			23a. Paru. Enter the disease, or comp	lications that caused the deal	Do not enter the	ne mode of dying, suit	g to N St. (	piratory arrest,	deje M	Approximate
F	Physician		sh ck, or heart failure. List only of Immediate Cause (Final disease or condition	Fixed St	ma Hi	V Todas	from			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	(ue of):	y you	27.1-7-5			2/3
	Examiner	_	Sequentially list conditions,	b. Renal Due to (or as a conseq	Pople	no				140
	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	dence or).					
5	exection and rial-tra		that initiated events resulting in death) Last	Due to (or as a conseq	quence of):					
0 .	cate be executed physicien and the burial-transit	dicai	(	d						
Š į	entific ding p	/Mec	IF FEMALE:	23c. If yes, outcome of pregna	2004					
	eath c	by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	al death 3 ⊟Ect	opic pregnancy her (specify)			23d. Date of delive Month	Day Year
	t the c by the tached	hysi	9 Unknown	9□ Unknown		,,,,				
cords, r	w requires that the death certifit been signed by the ettending p should be detached for use as		Part II. Other significant conditions co	intributing to death but not res	sulting in the under	lying cause given in P	Part I.	23e. Did tobacco		the cause of death?
י שבי	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  Within 24 hours after death.  To the Funerial Director: After this certificate hes been signed by the estending prompletely filled in by the funeral director, page 2 should be detached for use as	Completed						24a. Was an autopsy performed? Per 2 12 14 14	death?	opsy findings available ompletion of cause of
N	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:	TERIO :	Othor	Place of Death (Ch			
	th. : After this s funeral d	ıtlon: To	27. Manner of Death  1 Selatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		5 Residence Describe how inju		rfy)
DIVISION	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funarel Director: After this certificate hes completely filled in by the funeral director, page 2 to	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fy)	factory, office	28f. L	ocation (Street a. City or Town, Stat	nd Number or Rur e)	ral Route Number,
	n 24 hour n 24 hour he Funara pletely fille	Medical (	29a. Certifier (Check only one) Certifying Phyone Control on the Certifying Phyone Certifyin Phyone Certifying Phyone Certifying Phyone Certifying Phyone Ce	ysician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death oc ation and/or invest	curred at the time, date	te and place, and o death occurred at	ue to the cause(s the time, date an	and manner as a d place, and due	stated. to the cause(s)
1	To the comp	Σ	29b. Signature and title of certifier	200		29c. License numb	- 00		ate signed (Month,	
			I la land text	due		D060	500	Thu	just 14	2006
			30. Name and address of person who c	completed cause of death (Item	11	( Heales	kmli	2/6/12		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa		3 1/40)/00/	~ / /	1070		
	Registr	rar	AUG 1 4	2006	K A	mark!				

		-	For State Registrar	State of Mar	•	artment of H		d Mental F	lygiene Reg. No	4 U U t	27053
			1. Decedent's Name (First, Middle, Last	)				2. Date of Month	Death Da	y Yea	3. Time of Death
	Physici /Medic	14	Geraldine Mildred	Wheeler				August		2006	9:55 p <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of D	eath		. County of D	
			Waldorf Health Ca 5. Social Security Number 6. Se		Married to the facility of the	Waldorf If Under 1 Year	If Under 24	Hrs 0 Data of		Charles	
ľ	Funeral Director			14 aV1c	In yrs. last birthday) 79 Yrs.	Months Days		Ain. (Month,	Day, Year)		Birthplace (State or Foreign Country) irginia
	pu 🖈		Usual Residence of Decedent  10a, State 10b. County		Oc. City, Town or Lo	ncation					10d. Inside City Limits
	sho	ō	Maryland Charles		Indian H						1X Yes 2 □ No
	28a-i	Director	10e. Street and Number		тицтан п	10f, Zip Code			10g. Ci	tizen of What	Country?
	3a or		1009 Kenneth St.			20640			U.	,	
	death ms 2	nera	11. Marital Status	12. Was Decedent Ev	er in U.S. 13.	Was Decedent of Hi	spanic Origin	? (Specify Yes or	_	14. Race - A	merican Indian,
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or itams 23a or 28a-f show or other traumatic evant, the Medical Examinate and traumatic evant, the Medical Examinate and the control of th	by Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2 <b>X</b> No	Specify:	ueno rican, etc.)		Black, W	nnie, eic. Thite
Ö	hours tural	d be	3   Widowed 4 □ Divorced  15. Decedent's Edu	Year or Dates:	16a Decer	dent's Usual Occupa	ation		16h W	(ind of Busine	
7	in 72 "nai ledic	Completed	(Specify only highest grad	e completed)	(Give	kind of work done of DO NOT use retired	during most of	working	100. 6	and of busine	ss/mustry
72	within liene.	шо	Elementary/Secondary (0-12)	College (1-4or 5+)		maker			He	r Home	<u>:</u>
פַ	e filed Il Hygid othar vant, Il	Bec	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Mid	dle, Maider	Sumame)	
Maryland 21215-0036	should be and Mental Is marked o	70 E	Howard Alton Whee	ler			Alice	Griffir	l		
lan	2 should be and Mental is marked or raumatic eva	r i	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailir	ng Address (Street a	and Number o	r Rural Route Nu	mber, City	or Town, Stat	e, Zip Code)
	Health tem 27			ON	1009 20b. Place of Dispo	Kenneth S	St. In	dian Hea	_		or Town, State
Jor	iges 1 if of h if ite or ot		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ F		cemetery, crei	matory or other plac	1			2.370	
Baltimore,	it. Partmer	1	<ul> <li>4 ☐ Donation 5 ☐ Other (Specify)</li> <li>21. Signature of Funeral Service Licens</li> </ul>	- 4	Chicamuxe	n Church 2. Name and Addres		/8/2006	Chi	camuxe	n, Maryland
Ba	permit. Pages 1 am Department of Heali Important: If item 2 any injury or othar once.		1 mil In	111	моо668 4	illiams F 270 Hawth	uneral orn Ro	Home, Fad Indi	.A. an He	ad, MI	20640
	Physician and reduced by see as the purial-transit	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failuse. List only of limited the conditions of the conditions of the conditions of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a or Due to (or	consequence of):  Consequence of):  Consequence of):  Consequence of):	A , Au	nza	men ?	<b>5</b> .	æ .	Approximate Interval Between Onset and Death A Years
8760,	ate be e hysiciar the buri	dlcall									
.O. Box 6	death certific e attending p ed for use as	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	□Ectopic pregnancy □ Other (specify)			-	23d. Date of delivery Month Day Year			
ds, P	es be		Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause give	en in Part I.			pacco use contribute to the cause of death?	
Record	e law has b	Completed							itopsy erformed?	prior death	autopsy findings available to completion of cause of 17 fees 2 \square No
Vital	ician: Th certificate rector, pag	a l	25. Was case referred to medical				26. Place of	Death (Check on		, , , , , , ,	50 20110
of V	Physician: this certific ral director,	To B	examiner? 1 D Yes 2 No	dospital: 1   Inpatient	2 ER/Outpatier	nt 3□ DOA Othe	er: 4 Nursir	ng Home 5□R	esidence	6 Other (S	(pecify)
o uo	ing After une		27. Manner of Death  1 ★Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	/ear) 28b. Time o	Work	yat k? Yes 2 □ No	rsing Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred			
Division	or At ifter o Dirac in by	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, str (Specify)	reet, factory, office		28f. Locatio City or	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	To tha Hospital or Att within 24 hours after d To the Funaral Diract completely filled in by	edical (	29a. Certifier (Check only one)	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	h occurred at the tim vestigation, in my op	ne, date and p pinion, death o	lace, and due to to courred at the time	he cause(s ne, date an	) and manner d place, and d	as stated. due to the cause(s)
)	To the To the Comp	M	29b. Signatule/and title of certifier	tale t	) mi	29c. License	number	29	29d. Da	te signed (Mo	onth Day, Year)
1			30. Name and address of person who co	ompleted caryse of dea	th (Item 23a) (Type,	Print)	- 00			0 1	100
(	<u>B5</u>	10	31. Date filed (Month, Day, You)	J. WAT	Drin 1	1. D.	NAI	LDOR	6-, r	nd.	20603
	Sta Registi		AUG 1 4		w & A	berle					

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Charles Roland Walsh 12, Sr. 10:34 a<sup>™</sup> August 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore 4330 Butler Road Glyndon If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1.XM 2□F 51 Yrs 213-64-3727 Maryland Director Dec 31, 1954 Usual Residence of Decedent with the Maryland 10c, City, Town or Location 10d Inside City Limits 10a State 10b. County r than "natural", or Itams 23a or 28a-f show the Modical Extra illustroust be notified at Glyndon 1 ☐ Yes 2 No Baltimore Maryland Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21071 4330 Butler Road USA death Funeral 12. Was Decedent Ever in U.S.
- Armed Forces?
1 ☐ Yes ② No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filad within 72 hours after Hygiene. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Specify: ģ white 3 ☐ Widowed 4 M Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Farm Elementary/Secondary (0-12) Horse Groomer 10 Pages 1 and 2 should be filad and of Health and Mental Hygis int: If itam 27 Is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Carry Weinhold George Patrick Walsh, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 1312 N. Main St. Box 413, Hampstead, MD 21074 Christina Walsh, daughter or othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 08/16 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
1 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or once. Winfield. MD South Carroll Crematory 2006 22. Name and Address of Facility
Myers-Durboraw Funeral Home
91 Willis Street Westminster, 21. Signature of Funeral Service Licensee M01191 MD 21157 23a. Part Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiovascular Artonioscleso Physician 5 Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to or as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit The law requires that the death certificate be exacuted Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy rmed? 24 No certificate 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) 2 After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🗆 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. of the of certifie 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature D1866 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Trimble H:11 CT. Lutherv: 1/e, MI) 21093 Philip Militello, MI) 31. Date filed (Nonth, Day, Year) State Elmen & Spark AUG 1 4 2006 Registrar

		•	For State of Registrar	Maryland / De	epartment of I Dertificate of			iene 200	5 27055
			Decedent's Name (First, Middle, Last)				2. Date of Death Month	n Day Yea	3. Time of Death
	Physici /Medio		Barnsley Edgar Warfield,				August	11 2006	5:30 a.m.
À	Examin	er	4a. Facility Name (If not institution, give street and num.	ber)	4b. City, Town, G Bened:	or Location of Deal	th	4c. County of De	
			7194 Benedict Ave.  5. Social Security Number 6. Sex 7	. Age (In yrs. last birtho			9 Date of Birth	Char	
И	Funeral Director		579-38-8173   1⊠ M 2□ F	76 Yrs	Months Days			Year) 9. 0 20 Ma	inthplace (State or Foreign Country) ryland
	D		Usual Residence of Decedent				0 14 17.	2) 114	ryrand
	anylan ahow		10a. State 10b. County	10c. City, Town o	or Location				10d. Inside City Limits
	8a-f	octo	Maryland Charles		Benedict				1 ☐ Yes 2 No
	with th	Ö	10e. Street and Number 7194 Benedict Avenue		10f. Zip Code 2061	2	10	og. Citizen of What	
	ne 23	erai		lent Ever in U.S.	13. Was Decedent of I		Specify Yes or No-		States
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "neturel", or Items 23a or 28a-f show say injury or other traumatic event, Ite Medical Examinational Landing at Once.	by Funeral Director	Armed Force  1 Never Married 2 Married  1 Yes Cive  3 Widowed 4 Divorced  Armed Force 1 Yes Cive 1 Yes Cive Year or Dal	es? 2 No	If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)	Black, Wi	white
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	100	ecedent's Usual Occu Give kind of work done	during most of wa	ntkina	16b. Kind of Busines	ss/Industry
7	hen.	m jd	Elementary/Secondary (0-12) College (1-	4or 5+)	ife. DO NOT use retire	d)		D.1	
2	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)		Educator	18 Mother's Na	me (First, Middle, N		ucation
ano	d be sed o	To Be	Barnsley E. Warfield					Henderson	
چ	shoul nd Man	)=	19a. Informant's Name/Relationship (Type, Print)	19b. N	Mailing Address (Street	and Number or R	ural Route Number,	City or Town, State	, Zip Code)
ž	alth a		Hazel C. Warfield/Wife	P.0	. Box 135.	Benedict	t. Marvla	nd 20612	
ore,	of He		20a. Method of Disposition	20b. Place of D	isposition (Name of crematory or other pla	ce)		20c. Location - City	or Town, State
Ĕ	Page ment ant: If ury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	tate	eld-Echole	Cro 8-1	2-2006 CI	harlotte	Hall MD
Baltimore,	Depending Depending Import only in Succession on the Succession of		21. Signature of Funeral Service Licensee		22 Name and Addre Brinsfi 30195 T	eId-Ech hreeNot	ols Fune	eral Hom	e,P.A. e Hall,MD
			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. Do not ch line.					Approximaté Interval Between
)	Physician			ophageal	Concer				Onset and Death
	/Medical Examiner		resulting in death)  Due to (co	r as a consequence of)	:				
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	uted J ansit	Examiner	cause. Enter Underlying Cause (Disease or injury						
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8760,	icate be executed physicien and s the burial-transit	dicai	d						
9 ×	ertifica ling pl	Med	IF FEMALE:						
D. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	in the past 12 months?	ome of pregnancy th 2 ☐ Fetal death nt at time of death vn	3 ☐Ectopic pregnand 5 ☐ Other (specify) _	у		23d. Date of d Month	lelivery Day Year
Division of Vital Records, P.O.	that the ed by detac	/ Ph	Part II. Other significant conditions contributing to dea	th but not resulting in th	ne underlying cause gr	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
rds	tw requires that s been signed I s should be det	Q D	Chremic Obstructive Pulsanong Oliceric Wes						Probably 4 Dunknown
Ö	s bee	jete		,			24a. Was ar	24b. Were	autopsy findings available
Be	The la	mo om					autopsy perform 1 ☐ Yes 2	/ prior t	o completion of cause of
ital	intifice	BeC	25. Was case referred to medical			26. Place of De	ath (Check only one		
Ž >	hysic his ce I direc	ToE	examiner? 1   Yes 2   No   Hospital: 1   In	patient 2 ER/Outpa	atient 3□ DOA Ot	her: 4 🗆 Nursing I	Home 5 X Reside	nce 6 Other (Sp	pecity)
Ē	ing P	Co	27. Manner of Death 1.⊠Natural 5 □ Pending 28a. Date of (Month)	Injury 28b. Tim , Day Year) Inju	ıry Wo		28d. Describe ho	w injury occurred	
isio	ttend death stor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	d laius. At homo form		]Yes 2□No	29f Location /Cts	root and Number or	Dural Day to Muse have
<u>&gt;</u>	after Direction by	Certification:	4 Homicide determined 289. Flace of building	of Injury - At home, farm g, etc. <i>(Specify)</i>	i, street, ractory, onice		City or Town		Rural Route Number,
	To the Hospital or Attending Physician: The lav within 24 Houris after death. To the Funeral Director Atter this certificate has completely filled in by the funeral director, page 2		29a. Certifying Physician: To the t	pest of my knowledge, o	death occurred at the ti	me, date and place	e, and due to the ca	use(s) and manner	as stated.
	he Ha n 24 h he Fu oletely	edical	(Check only 2 Medical Examiner: On the base and manner	sis of examination and/o	or investigation, in my	opinion, death occ	urred at the time, da	ite and place, and d	ue to the cause(s)
	To ti To ti comp	M	29b. Signature and title of certifier		29c. Licen			d. Date signed (Mo	* * * * * * * * * * * * * * * * * * * *
	æ		Davd & healo.	W Con	0	17610	/	א אנייקניף	1 2006
	1 C		30. Name and address of person who completed cause					WD 004=0	
			David J. Tardio, MD 31. Date filed (Month, Day, Year) 32,49e	, 110 Hospi gistrar's Signature	tal Road, P	rince Fr	ederick,	MD 20678	
	Sta Registr	-	St. Date filed (Merial), Day, Tour,	gistiai s Sigilature	book				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** August 17, 2006 7:23 a.m. Thompson Woods /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's 25335 Three Notch Road Hollywood 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 ☐ M 2 🗓 F Yrs. Maryland 1949 57 May 4, 219-56-0468 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County worde. item 27 is marked other than "naturel", or items 23a or 28e-f show other traumatic event, the Mudical Examinat must be notified at 1 Tyes 2 No Director Hollvwood St. Mary's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20636 25335 Three Notch Road death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: ģ 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Comple filed within 7 Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 5+ 12 should be filed w h and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be Ann Elizabeth Lloyd James Harry Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) is 1 and 2 s of Health an 25335 Three Notch Road, Hollywood, Maryland 20636 Storm Allison Woods/ Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Importent: If Itel
any injury or oth cemetery, crematory or other place) Mary Immaculate Heart of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8-22-2006 Lexington Park, MD 22. Name and Address of FacilityBrinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22955 Hollywood Road, Leonardtown, MD 20650-0279 M01206 Kyle S. Simors 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause of seath line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine the Hospitel or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funerel Director: After this certificate has been signed by the ellending physicien and mpletely filled in by the funeral director, page 2 should be detached fur use as the buriat-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 4 Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Xinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2X No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death Injury 1 XVatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funerel C Celtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatur title of certifie 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24035 Three Notch Road, Hollywood, Maryland 20636 Patrick Cross, M.D., 31. Date filed (Month, Day, Yea AUG State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** AUGUST 12:30 P M DOROTHY WALTERS WILLIS 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CORSICA HILLS NURSING HOME QUEEN ANNE'S CENTREVILLE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09/02/1918 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 ☐ M 2 🗓 F MD 87 219-07-1113 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f ehow I Heelth and Mental Hygiene. Item 27 Is marked other then "naturel", or Iteme 23a or 28a-f ehov other traumatic event, the Modical Examinational be notified at 1 ☐ Yes 2 ☑ No Director QUEEN ANNE'S QUEENSTOWN 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ~ 21658 USA 7105 SECOND AVENUE Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Completed by 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Depertment of Heelih and Mental Hygiene. Important: If item 27 is marked other then "na eny injury or other traumatic event, the Madia 2006. College (1-4or 5+) Elementary/Secondary (0-12) BANKING BANK TELLER 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be NORMAN PRICE WALTERS DORA MAE WALLS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. BOX 215, QUEENSTOWN, MD 21658 THOMAS B. WILLIS, JR./SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □Donation 5 □Other (Specify) CHESAPEAKE CREMATORY 08/14/2006 STEVENSVILLE. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, 408 S. LIBERTY STREET, CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic 000 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner anding physicien and use as the burial-transit so the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month ō in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes Division of Vital After this certification, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation s after deural Director: After 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 Homicide within 24 hours a

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

Semra Sayna

31. Date filed (Month, Day, Year) 1 4 2006 AUG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 degistrar's Signature BldgB

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0051786

Chestertain MD 24620

29d. Date signed (Month, Day, Year)

Hug. 14. 2004

			1 - State Amend #31 p	State o	f Marylan Phys 08	nd / Depa -14-20/	rtment	of Head	alth and l eath	Mental Hy	giene Reg. No.	211116	27056
	Physicia	an	1. Decedent's Name (First, Middle, Las.	")	-					2. Date of De Month	Day		3. Time of Death
	/Medic	al	HAZEL  4a. Facility Name (If not institution, give	VIRG		WEIGI			ocation of Deat	AUGUS		2006 County of Death	12:41P M
	Examin	er	FREDERICK MEMO		,	AL	FRED					REDERI	CK
	Funeral		Social Security Number     6. Security Number		7. Age (In yrs.	**	If Under 1		f Under 24 Hrs Hours Min.	8. Date of Bi	rth av .Year).	9. Birth	place (State or Foreign
	Director		213-09-8262 Usual Residence of Decedent	□M 2√F	93	3 Yrs.		July 3		Sept.	16, 1	1912 Mary	y I and
	ahow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
:	a-fah	ctor	Maryland Frederi	ck	Ti	nurmont							1 Yes 2 □ No
3	or 28	Director	10e. Street and Number 506 East Main Str	aat			10f. Zip 0	code 21788	2		10g. Citi	Citizen of What Country? U.S.A.	
	na 23a	Funeral	11. Marital Status		edent Ever in U	.S. 13. V				specify Yes or N	0-	14. Race - Americ	can Indian,
<b>.</b>	or iten	Fun	1 Never Married 2 Married	Armed Fo 1 ☐ Yes If Yes, Gir	rce <del>s?</del> 2 (4-No	l II	Yes, specif	y Cuban,	Mexican, Puèr Specify:	to Rican, etc.)		Black, White,	
3	ural',	d by	3 XWidowed 4 ☐ Divorced	Year or D							1		White
2	n /2 n	olete	15. Decedent's Ed (Specify only highest grad	de completed)		(Give	lent's Usual kind of work DO NOT use	done duri	on ing most of wo	rking	16b. Ki	ind of Business/In	dustry
7	giene.	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)		Homem	aker				Own Hor	ne
3	2 should be lied within 72 hours atter deeth with the Maryland 2nd Mental Hygiene. 1a marked other than "natural", or itema 23a or 28a-f ahow eumatic avant, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last) Charles A. Kuhn							Mother's Name (First, Middle, Maiden Sumame) ary Alice Lewis			
y	should nd Men marke umatic	ဥ		vne Print)		19b Mailin	n Address /					r Town State Zin	Code
_ (	and 2 s ealth an n 27 la i		19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 11 South Carroll Street, Thurmont, MD 2										788
,	of Head of Head of Head of Head of Head		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Domoval from		Place of Dispo	natory or oth	er place)		Date		ocation - City or To	
	ment of I		4 ☐ Donation 5 ☐ Other (Specify		Re	1			dens 8/			lerick, l	
	permit. Pages 1 and 2 should Department of Health and Men Important: If Itam 27 ia marke any injury or other traumatic. <u>once.</u>		21. Signature of Funeral Service Licen	100	2.1							HOMES,	P.A.
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	lications that	alleged the deat	th. Do not ente	5 EAS or the mode	T MA. of dying,	IN ST., such as cardia	THURMO c or respiratory	NT, Narrest,	4D 21788	Approximate
F	Physician		Immediate Cauce (Final disease or condition	on e	A.	myap	alhia						Interval Between Onset and Death
f	/Medical Examiner		resulting in death)	Due to	(or as a conseq		41.14				·		
	-xammer	er	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq	uence of):							
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events  C.										
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	cate be executed physicien and the burial-transit	dicai	•	d									
<b>S</b>	es that the death certific igned by the attending p be detached for use as	V/Me	IF FEMALE:	23c. If yes, ou	tcome of pregna	ancy						23d. Date of deliv	erv
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	at the d by th etache	Phys	9 Unknown	9 Unkn									
<u>֓</u>	signed	ρ	Part II. Other significant conditions co	entributing to d	eath but not res	sulting in the ur	nderlying ca	use given	in Part I.			v	he cause of death?
Ś	been s	letec								24a. Wa		, –	posy lindings available
	ne lav	Completed								auto perf	opsy ormed?	prior to co death?	mpletion of cause of
	rtificat	BeC	25. Was case referred to medical					2	6. Place of De	1 ☐ Yes ath (Check only	2 No one)	1 Yes	2L No
<u> </u>	ding Physician: The h. After this certificate h. funeral director, page	To E	10 105 2000			ER/Outpatien						6 □Other (Special	(y)
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FFEMALE:   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   5						wn, State	"						
						and manner as s place, and due to	stated. the cause(s)						
:	o tha o tha omple	Med	29b. Signature and title of certifier	and man	ner stated.		29c.	License n	umber		29d. Dat	te signed (Month,	Dey, Year)
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£	り		30. Name and address of person who	completed caus	se of death (tter	m 23a) (Type,	Print)		To a Da	nick	MA	01743	
			Hemen Shah, 6 31. Date liled (Month, Day, Year)		Bgistrar's Signa		sen !	>Y'	+ recre	VIE K	,,>	21102	
	Sta Registr	ne	A COMPLET A 2	<del>996</del>	and and	K A	- 40						

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 20, **Physician** 2006 6:30am ELIZABETH WHELAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 459 Foxes Lane Earleville Cecil If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 STF 171-10-3826 Director 96 Aug 6 1910 New Jersey Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Examinar must be inclined at 1 Yes 2 No MD Ceci1 Earleville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 175 Foxes Lane 21919 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Merial Hygiene. and If item 27 is marked other than "natural, or flaury or other traumatic event, the Medical Enging ray or other traumatic event, the Medical Enging any 1 Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) own home homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bridget Conway Philip J. Doyle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25 Fingerboard Schoolhouse Rd. Earleville John Whelan (son) 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Aug 25 2006 Galena, MD Galena Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fulleral Service Licros 22. Name and Address of Facility Galena Funeral Home of St 118 W. Cross St. Galena, Home of Stephen L. Galena, MD 21635 Schaech м00510 Parts Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nos ulmorou /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to consequence of): Examiner (or as death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b rector, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) daughter's Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Speamesidence 1 ☐ Yes 2 X No 2 after death.

Diractor: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No М 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify) determined after 4 Homicide To the Hospitel o within 24 hours aft To the Funaral DI completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 100060756 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 Main St. Elkton. MD 3 ksay gan 31. Date filed (Month, Day, Year) 32/19 egistrar's Signature State AUG 2 5 2006 Registrar

## Plea:

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Registrar  1. Decedent's Name	(First, Middle, Las	st)			uncate of	Dealli	2. Date of De	Reg. No.		3. Time of Death	
Fevronia		•					Month	Day 21, 2	Year	2:35 A <sup>M</sup>	
4a. Facility Name (If			-		4b City Town o	r Location of Deat			ity of Deat		
Future Ca	_				Balti		,	70.000	n/a		
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11. Marital Status	a demonstration	12. Was Decedent I Armed Forces?		13. \	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				- 14. Race - American Indian, Black, White, etc.		
1 ☐ Never Married 2 ☆ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			10	1 ☐ Yes 2 <b>/2</b> No <i>Specity</i> :			Spec	Specify: White			
	15. Decedent's Ed fy only highest gra			16a. Deced	lent's Usual Occup	ation during most of wo	rkina	16b. Kind of	Business/	Industry	
Elementary/Secon		College (1-4or 5	+)	life. I	DO NOT use retire	d)	········ <i>y</i>				
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17. Father's Name (F							me (First, Middle		ame)		
Andrew A	Aleksoglu	1				Katina	Alekso	glu			
19a. Informant's Nar	me/Relationship (7	Type, Print)		19b. Mailir	ng Address (Street	and Number or Ru	ural Route Numb	er, City or Tow	m, State, Z	lip Code)	
Mr. John	Avramidis	s / Son		3443	Skyviev	v Drive	Glenvil	le , PA	. 173	329	
20a. Method of Dispo		ID	20b. Plac	e of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Location	n - City or	Town, State	
	」Cremation 3 ∐ 5 ☐ Other ( <i>Specif</i> )	Removal from State			thodox Co	· m a	23/06	Wood1a	wn. N	Maryland	
21. Signature of Fun				22	. Name and Addre		oudon P				
- un	ene	Cart	h	3	620 Wilke						
23a. Part1. Enter the	e disease, or domi	plications that caused	the death.						Jan	Approximate	
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirato shock, or heart failure. List only one cause on each line.  Immediate Cause (Final									Interval Between Onset and Death		
disease or condition a.			A.a.	125	ual	the	40			1 MO	
,		Due to (or as	a consequer	nce of):	, ,					in	
Sequentially list con	iditione,	b. Due to (or as	402	(C) E.	とちら					4,1	
if any, leading to imr cause. Enter Under Cause (Disease or in	lying niuny	28 10) 01 600	a c —equer	01).	00.00					1111	
that initiated events resulting in death) La		c. Due to (or as	a c. ne que	200	10 mm					7 14	
		Due to (or as	z compaction	DA	11	Mitn	76			1 mi	
		d	7	141	l l	uun	4			V = 1	

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

**Examiner** 

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturel", or iteme 23a or 28a-1 show any injury or other treumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

Be

		a.
it, ate	-	b.
4		C.
	l	d.

Mr.	Due to (or as a consequence of):
ь.	HYPERTERATO
	Due to (or as a c equence of):
c.	1 Perliped ann
	Due to (or as a cunsuquence of);
d	Dist wel

1 HO 40	1 1000
	yry
in	YM
well it IF	My
egnancy	23d. Date of delivery

Examine Be Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Medical Certification; To

1 ☐ Live birth 2 ☐ Feta	al death
4 Pregnant at time of o	
9□ Unknown	

3 □Ectopic pregnanc	У
5 Other (specify)	_

	23d.	Date o	f delivery
- 10		Month	Da
- 11			

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DL

23e.	Did	tobacco	use	contribute	o to	the	cause	of	death?
		\ \							

13 Henric	Carry	Arthy	Din
			24a.
			10

1 ☐ Yes 2	No	3 Prob	ably	4 Unknow	n
. Was an autopsy performed?	24b.	Were auto prior to co death?	psy fin mpletic	idings available on of cause of	Θ
Ves 2VINO		1 TYes	2 N	lo.	

					24a. Was a autops perform 1 Yes 2
case referred to medical				26. Place of Deatl	h (Check only on
niner? Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3□ DOA	Other: 4 Valursing Ho	me 5 Reside

	1 ☐ Yes 2	No 1 ☐ Yes 2	≥□ No
26. Place of Death (C)	heck only one)		
Other: 4 Mursing Home	5 Residenc	e 6 □Other (Specify)	

25. Was case referre examiner?		26. Place of Death (Check only one)						
1 Tes 2				3□	DOA Other: 4	Nursing I	Home 5 Residence 6 Other (Specify)	
27. Manner of Death 1 Matural 2 Accident	investigation		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe how injury occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stree	t, fact	ory, office		28f. Location (Street and Number or Rural Route Number City or Town, State)	

		T.	
29a, Certifier (Check only one)	1 Certifying Physicien: To the be 2 Medical Examiner: On the basis and manner	it of my knowledge, death occurred at the time, date and place, and due to the of examination and/or investigation, in my opinion, death occurred at the time stated.	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
001 0	of Alaba and an artifles of	CO - Linna	Ond Data sissed (Month Day Vasa)

one)	and manner stated.	gation, in my opinion, doubt beginning at the time	
29b. Signature and title of certifier	Maa	29c. License number	29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) AUG 2 8 2006

O

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Tannor Print in Black Indelible lake Four All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 6:58 PM AUG 100 23 WINITI 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT AGNES BALTIMORE HOSPITAL Il Under 1 Year If Under 24 Hrs. 8. Date of Birth (Mooth, Day, Year) Birthplace (State or Foreign County)) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 217-20-435 1 M 2 F 14 Yrs JUNE 28, 1922 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside Gity Limits 28a-f ehow item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Modical Examinar organ be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10 ock 122 deeth Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 2 Married 1 Never Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mentel Hygiene. ATERE 18. Mother's Name (First, Middle, Maiden S 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be RICE 2 nnson 199 Informant's Name/Relationship (Type, Print), 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other 09 W000 120 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of H
Important: If ite
any injury or of 1 ■ Burial 2 □ Cremation 3 □ Removal from State 30 4 ☐ Donation 5 ☐ Other (Specify) 2006 Dutus MEM. VC 21. Signature of Foneral Service License un ionEs BROAD WAY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) WEEKS /Medical Due to (or as a consequence of): **Examiner** LUNG MUNTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed CORONATY MONTHS that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ettending physicien Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown peed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy perform certificate 2 No 1 Yes To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1/X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined efter 4 Homicide within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number M.D AUG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 BALTIMORE AVE. mo 900 CATON 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 2 8 2006

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 27062 1- For Phy g859 9/06/06 Chtificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Year August 27, 2006 Virginia Mary Blades Virginia May Blades 9:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 501 Morningside Drive Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 21X F Yrs. Director 267-12-1801 May 1920 86 Washington, D.C Usual Residence of Decedent the Maryland 10c. City, Town or Location or 28a-f ehow 10b. County 10a. State 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or iteme 23a or adical Examiner must be 501 Morningside Drive 21061 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②XNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Itel 1 ☐ Never Married 2 Married Baltimore, Marvland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Jeremiah B. McPherson Roxie Elizabeth Thompson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Blades / Husband 501 Morningside Dr., Glen Burnie, MD 21061 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) August 2006 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Pk. 4 □ Donation 5 □ Other (Specify) Glen Burnie, Maryland e of Euneral Service Licenses 21. Signat 22. Name and Address of Facility Impor eny in Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Injerval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury yo years death certificate be executed attending physicien and for use as the burial-transit Hyperteni Exam that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 🖾 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has birector, page 2 s 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 ☒ No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 X Natural 5 Pending death. 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 0 To the Hospital o 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)50254 August 28, 2006 Nom 2 marge 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahador Momeni, M.D., 8601 Veterans Highway, Millersville, Maryland 21108 31. Date liled (Month, Pay, Year) AUG 2 8 2006 32. Pastrar's Signature State Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 27063

		- For State Registrar	Ce	rtificate of D	eatn		g No.	000 2700
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle, L	BACOAt			2. Date of Deat Month August 17	h Day Year , 2006	3. Time of Death 1400 hrs
	ľ	4a. Facility Name (if not institution, 2503 Liberty Heights Av			City, Town, or Location Baltimore		4c. County of	Death
Funeral Director	C	318-07-5735	Sex 7. Age (In yrs.		f Under 1 Year If Under 1 Year		6-16	9 Birthplace (State or Foreign William)
ne Maryland or 28a-f show any fied at once.		Usual Residence of Decedent  10a. State 10b. County	A 10c. City	Alti MOE	E.			10d. Inside City Limits 1 Ves 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once	Dir.	10e. Street and Number ().	jety Hats.	AVE. 1	0f. Zip Code 201215	10	og. Citizen of Wha	S, A
77	by Funeral		1 Yes 2 No ed If Yes, Give Year or Dates:	If Yes,	specify Cuban, Mexica No specif	y:	White,	BLACK
5-0036 led within 72 hours after Hygiene o ther than "natural", the Medical Examine.	Completed	15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade completed)  College (1-4 or 5+)		Jsual Occupation (Givorking life, DQ NO	T use retired)	PAIL	iness/Industry
121 Id be fill Aental F narked event, e	To Be Co	17 Father's Name (First, Middle, La Bould SA 1 a Informant's Name/Relationship	OAT (Type, Print)	19b. Mailing Ay	18.Moth	er's Name (First, Middle A	Jaiden Swrname) JAZ Jojer, City or Town	State de)
nd 2 alth a	K	20a. Method of Disposition  1 Burial 2 Cremation	Removal from State	Place of Disposition crematory or diher	(Name of cemetery, blace)	0 101: VIII	20c Lecation	City or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite	ŀ	4 Donation 5 Other Special 21. Scripture of Fuyeral Service un	<del></del>	1000 NV	OUNT e and Address of Facil DN, EA	HEATT	1039	8.M. 21202
Physician /Medical		failure. List only one cause or	mplications that caused the death each line a. Atherosclerotic Cardio			cardiac or respiratory arre	est, shock, or hear	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence		3C			
All		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b.  Due to (or as a consequence of c.  Due to (or as a consequence of consequence					
760, ficate be executed 3 physician and the burial - transit		events resulting in death) Last  UNPENDED	d AMENDED					
00 E E S I	sician/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknot	23c. If yes, outcome of pred  1 Live birth 4 Pregnant at time of d	2 Fetal	death 3 Ector	pic pregnancy	23d. Date of o	delivery Day Year
P.O. Box 6: s that the death cen gred by the attendi	- 1	Part II. Other significant condition	- 10 - 10 - 10 - 10 - 10 - 10 - 10 - 10	resulting in the und	erlying cause given in I			ute to the cause of death?
Division of Vital Records, P.O rat or Attending Physician: The law requires that the safter death.  The law requires that is the continuate has been signed by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	Completed by	Prostate cancer				24a. Was a	an 24b. W	Probably 4 V Unknown  Vere autopsy findings available ior to completion of cause of sath?
tal Rec cian: The certificate ector, page		25. Was case referred to medical	_			h (Check only one)	2 <b>V</b> No 1	Yes 2 No
F Vita Physicia or this ce	To Be	examiner?  1 ✓ Yes 2 No  27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatient 3			Residence 6	
ision of Attending Ph r death. ector: After t	ation:	1 Natural 5 Pendin 2 Accident Investig		28b. Time of Injui	1 Yes 2		now injury occurre	a l
Divis pital or At ours after d teral Direc filled in by	Certification:	3 Suicide 6 Could redeterm	oot be 28e. Place of Injury - At h	nome, farm, street, f	actory, office building,	etc. 28f. Location (S or Town, S		r or Rural Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a Certifier (Check only 1 Certifying Physics)	sician: To the best of my knowled ner:On the basis of examination and manner stated	-				
	ž	29b. Signature and title of certifier	Cellen_		O.C.M.E.	er	29d Date signed August 18, 2	d (Month, Day, Year) 2006
	-	30. Name and address of person w	no completed cause of death (Iter		eet, Baltimore, M	D 21201		
		31 Date filed (Month, Day, Year)	32. Redistrar's Signa		ds)			
DHMH 17 Rev 1/20		<u> </u>	1,000 1 July 1,000	ORIGINAL				

				For State of Ma		artment of Health a tificate of Death	and Mental Hygiei	/ 1111   5	27064
_		Physici /Medic		1. Decedent's Name First, Middle Last)  ARTHENIA	Bouli	Nare	2. Date of Death Month AUGUST	26+h 2006	3. Time of Death
		Examin	199	4a. Facility Name (If not institution, give street and number) SAINT AGNES HOSPITA			ORE	4c. County of Death	
	ST.	Funeral Director	0	5. Social Security Number  6. Sex 1 □ M 2 ▼ 7. Age 1 □ M 2 ▼ 7. Age 1 □ M 2 ▼ 7. Age	(In yrs. last birthday) Yrs.	Months Days Hours	Min. (Month, Day, Ye	par) 9. Birthpl Coun 924 Nort	1' / .
		Maryland -f show	tor		10c. City, Town or Lo	cation & temo	٥	11	0d. Inside City Limits 1 ✓ Yes 2 □ No
		uth with the Marylar 23a or 28a-f show	i Director	10e. Street and Number Kossuth	St.	10f. Zip Code	10g.	Citizen of What Coun	itry?
	920	after des	by Funerai	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent E Armed Forces  1 Yes 2 No If Yes, Give Year or Dates:	) I	Was Decedent of Hispanic Ori f Yes, specify Cuban, Mexican 1 Yes 2 No Specify:	gin? (Specify Yes or No- i, Puerto Rican, etc.)	14. Race - America Black, White, C	
	21215-0036	be filed within 72 hours fal Hygiene. d other than "natural", event, the Medical Exa	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+	(Give	dent's Usual Occupation kind of work done during mos DO NOT use retired) Sed Practic	t of working 16b	Hospit	dustry als
	0	2 should be filed and Mental Hygie is marked other aumatic event, it	To Be C	17. Father's Name (First, Middle, Last)  James Brown	~	1 6	or's Name (First, Middle, Maid		msm
		7.2 ± 2		19a. Informant's Name/Relationship (Type, Print)  European Swann	101		er or Rural Route Number, Cit	ity or Town, State, Zip Baldo, md,	(Code)
	Baltimore,	0 0		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, crem	natory or other place)	8-30-06 A	Location - City or To	own, State Md.
	Balti	permit Page Department o Important: If any in ury or once.		21. Signature of ruleral Service Ligens	G	2. Name and Address of Facili	270 FredHILT		, md. 21229
4		Physician /Medical		resulting in death)	TENSIO				Approximate Interval Between Onset and Death MMOUN
EN		Examiner	97	SED	consequence of):  S15  consequence of):			v	inknown
PARTH	8760%	sate be executed thysicien and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	consequence of);				
Щ.	. Box 6	death certific e attending p od for use as	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at to 1 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	The same of the sa	23d. Date of delive Month	ery Day Year
NAR	rds, P	w requires that the s been signed by th should be detache	Ď	Part II. Other significant conditions contributing to death but DIABETES NELLIT			. 23e. Did tobacc	co use contribute to the	1/
BOULWAR	0	≥ D N	e Completed	PLEURAL EFFUS PERIPHERAL VAS 25. Was case referred to medical		DISEAS	24a. Was an autopsy performed 1 Yes 2	prior to cor	psy findings available mpletion of cause of 2X No
	of Vi	Physicia sr this cert eral direct	To B	examiner?  1  Yes 2 No  1  Inpatier  27. Manner of Death  1  Natural  5  Pending  (Month, Day		nt 3 DOA Other: 4 No	ursing Home 5 Residence 28d. Describe how i		у)
	Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation	Year) Injury ry - At home, farm, str , (Specify)	M 1 Yes 2		t and Number or Rura itate)	al Route Number,
	_	Hospital 24 hours Funeral etely filled	Medical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of 2 Medical Examiner: On the basis of and manner stat	examination and/or in	h occurred at the time, date ar vestigation, in my opinion, dea	nd place, and due to the cause with occurred at the time, date	e(s) and manner as st and place, and due to	tated. the cause(s)
		To the within To the comple	Me	29b. Signature and title of certifier    Wydoley Town	CF, MD	29c. License number P186	II AU		Day, Year) 3th, 2006
	0.0	↓ - Sta	ate	30. Name and ad as of person who completed cause of de QOO CATON AVENU.  31. Date filed (Month, Day, Year) 32 Aegistra  AUG 2 8 2006	ath (I m 23a) (Type, E BAL r's Signature	Print) MORE	MD 212	129	
		Regist	rar	AUG 2 8 2006	1 Dr Page				

#### Please Type or Print in Black Indelible Ink

epe Bennett		State of Maryland / Departmen	nt of Health and Mental H	2006 2706
Physicia		Registrar  1. Decedent's Name (First, Middle, Last)	0 01 000011	2. Date of Death 2006 3. Time of Death
ledical Exami		Pepe Bennett		Month Day 200 Year 0805 hrs
		Facility Name (if not institution, give street and number)  John Hopkins Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthd)		8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Director		216-98-9503 1XM 2 F 26	Yrs. Months Days Hours Min	- le
		Usual Residence of Decedent		Accession 1100.
w any		10a. State 10b. County 10c. City, Town or	Location	10d Inside City Limits 1 X Yes 2 No
vfaryland 28a-f show 1 at once.	tor	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
he Mar or 28	Director	15 Levland C+	2/22/	$11 \leq A$
with t ns 23a be not	ral		3. Was Decedent of Hispanic Origin? ( S	
death	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.
rs after ural", miner	à	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a De	1 Yes 2 No specify:	Specify Black work done 16b. Kind of Business/Industry
72 hou "nat	eted	Elementary/Şecondary (0-12) College (1-4 or 5+)	ring most of working life. DO NOT use reti	
5-0036 fled within 7. Hygiene I other than	Complet	12 0	arpentry	Construction
15-0 filed v I Hygi d oth		17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Maiden Surname)
MD 21215-0036 2 should he filed within 72 hours after death with the Maryland h and Mental Hygienell man "natural", or items 23a or 28a-faho arts must be other than "natural", or items 23a or 28a-faho innatic event, the Medical Examiner must be notified at once	To Be	19a Informant's Name/Relationship (Type, Print) (Mother) 19b	Mailing Address (Street and Number or I	Rur Route Number, City or Town, State, Zjp Code)
md 2 should be fi ealth and Mental lem 27 is marked traumatic event,		Ms. Emily Peterson 115	Leyland C	t. Balto, Md. 2/221
			Disposition (Name of cemetery, y or other place)	Date 20c. Location - City or Town, State
Baltimore, Department of Hee Important: If ite		4 Donation 5 Other Specify:	1	18/2006 Lansdowne, Md.
Baltimore permit Pages I Department of I Important: If	Y	21 Squature of Funeral Service Licensee	Joseph L. Russ	Funeral Home, P.A.
Physician		23 / Int I Entey the disease, or complications that caused the death. Do not of	enter the mode of dying, such as cardiac	
/Medical		Mailure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Gunshot Wounds		Between Onset and Death
		or condition resulting in death)  Due to (or as a consequence of):		
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
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0, e be execut sician and burial - tra	edical	UNPENDED X AMENDED I tem #2 Per	ME G858 8/28/06 JH	
Box 68760, e death certificate be the attending physic do for use as the bured bure.	n/Me	23b. Was decedent pregnant in the	Fetal death 3 Ectopic pregna	23d. Date of delivery ancy Month Day Year
Ox 6876 eath certificate attending phy for use as the b	sician/M	past 12 months?  4 Pregnant at time of death 5	Other (Specify)	
O. Boy t the deatl by the att	Phys	Part II. Other significant conditions contributing to death but not resulting it	n the underlying cause given in Part I	23e Did tobacco use contribute to the cause of death?
ires that the signed by	þ		The disconting cause given in a set.	1 Yes 2 ✓ No 3 Probably 4 Unknown
of Vital Records, ng Physician: The law require Niter this certificate has been si neral director, page 2 should b	Completed			24a Was an 24b. Were autopsy findings available prior to completion of cause of
eco he law ate has age 2 s	dmo	-		performed?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Records, ysician: The law requi	BeC	25. Was case referred to medical examiner?	26 Place of Death (Check	
F Vit Physic or this c	To E	1 Yes 2 No No Inpatient 2 Y ER/Out		ng Home 5 Residence 6 Other:
n of V uding Ph th. : After the funeral	ion:	1 Natural 5 Pending FOUND: Day, Year) FOUN	me of Injury 28c. Injury at Work?  ID: 1 Yes 2 ✓ No	28d. Describe how injury occurred Subject shot
Division tal or Atteudi rs after death. at Director: A	ertification:	2 Accident Investigation Aug 20, 2006 0216 28e Place of Injury - At home farm	n, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
Divis Hospital or A 24 hours after Funeral Dire	Serti	4 Homicide determined (Specify) Local Street		or Town, State) 1800 Blk North Montford Ave., Baltimore, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Furnaria Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	ical C	29a Certifier (Check only one) Wedical Examiner: On the basis of examination and/or inv		
To the within To the comp	Medical	2 Medical Examiner: On the basis of examination and/or invand manner stated  29b Signature and title of certifier	29c License number	29d Date signed (Month, Day, Year)
	-	(a softaeo.	O.C.M.E.	August 21, 2006
2		30 Name and address of person who completed cause of death (Item 23a)		
	Ų Į		enn Street, Baltimore, MD 2120	01
S Regis	tate	27.	Coule	
	-	111 11 7 13 111111	· Ar	_

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			For State Ragistrar	State of M	aryland / L		ment of He ficate of D				006	27066
, , , , , , , , , , , , , , , , , , ,	و و فر		1. Decedent's Name (First, Middle, Last)						2. Date of De Month		Year	3. Time of Death
	ysicia Medic			fman			,		Augus	t 23	2006	4:05 P <sup>M</sup>
Ex	amin	er	4a. Facility Name (If not institution, give s			4	b. City, Town, or L	ocation of Death		4c. (	County of De	ath
Lista II			Gilchrist Hospice Center Towson Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs. 8. Date of Birth 9. Birthpla									irthplace (State or Foreign
	eral ector			M 2X1F	00		Months Days	Hours Min.	04-28-	917	Ma	aryland
	-		Usual Residence of Decedent									
arylar ehow	ta ta	_	Maryland N/A		10c. City, Tow	vn or Locat timor						10d. Inside City Limits 1 X Yes 2 □ No
the M 28e-1	THE STREET	Director	10e. Street and Number		Dai	LIMON	10f. Zip Code			10= Citie	en of What (	
with o	3		0=40	enue				12.4				Souridy :
Jeath ne 23	Times of	Funeral		2. Was Decedent	Ever in U.S.	13. Wa	s Decedent of His es, specify Cuban		ecify Yes or No		.S.A. 4. Race - An	nerican Indian,
after o	9		1 Never Married 2 Married	Armed Forces					Rican, etc.)		Black, Wi	
ours a	E	l by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1	Yes 21X No	Specify:			Specify: W	Mhite
Maryland 21215-0036 ad 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other then "natural", or Iteme 23a or 28e-f ehow	the Mudical Exerciper must be mutiled at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a	(Give kin	it's Usual Occupat of work done du	iring most of work	ing	16b. Kin	d of Busines	ss/Industry
within the	N S	gm	Efementary/Secondary (0-12)	Colfege (1-4or		Homem	NOT use retired)				مال مدار	ma
Hygie A	mt, th	e Co	17. Father's Name (First, Middle, Last)			nomem		18. Mother's Nam	e (First, Middle		Own Ho	me
d be ental	0	To Be	Stanislau Gr	omacki				Jozef	a Civi	nciu	ska	
Taryla 2 should and Men 1 marke	treumatic	-	19a. Informant's Name/Relationship (Type	oe, Print)	196	b. Mailing	Address (Street ar					, Zip Code)
	er tre		Richard K. Coffma	n - Son	39	959 0	ld Feder	al Hill	Road 3	larre	ttsvil	le, MD 21084
Ore ges 1: If item	-		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place o cemete	of Dispositi ery, cremat	on (Name of lory or other place)		Date	20c. Loc	ation - City	or Town, State
IIMOT Pages Iment of I	ury		4 □Donation 5 □ Other (Specify)		Morela				8/2006	Balt	imore,	Maryland
Baltimore, permit. Pages 1 ar Depertment of Hea	iny inj		21. Signature of Funeral Service License	°Charles	Miner		lame and Address	-	53	05 H	arford	l Road
	<b>6</b> O		23a. Part1. Enter the disease, or compli	nations that sauce	od the death. Do						ore, M	laryland 21214
	#		shock, or heart failure. List only or firmediate Cause (Final	e cause on each	line.	1	11 1.	17166	or respiratory a	irest,		Interval Between Onset and Death
Physic /Med			disease or condition resulting in death)	the second second second	erebl		bleedin	15				weeks
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be getter	trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
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687 ificate to g physic	for use as the buria	dlca										
Box 687 sath certificate	ise a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome	e of pregnancy					2	3d. Date of d	lelivery
Geath death	d for (	clar	in the past 12 months?	4☐Pregnant a	2 Fetaf death at time of death		ctopic pregnancy other (specify)				Month	Day Year
	tached	hys	9 Unknown	9□ Unknown								W
<u> </u>	should be deta		Part II. Dther significant conditions cor	tributing to death	but not resulting i	in the unde	erlying cause giver	n in Part I.	23e. Did 1	obacco us	e contribute	to the cause of death?
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The The Cate h	al director, page 2	Con	Hypertension	and	Diabet	ies n	ne 11:tu	3	perfo 1 ☐ Yes	ormed?	death 1 🔲 Y	es 🐹 No
Vita icien certifi	ector	Be	25. Was case referred to medical examiner?	ospital:			Other	26. Pface of Deal				
Pry of	rald	. To	1 Yes 2 No	1 L Inpat		utpatient Time of		4   Nursing In	ome 5 Resi 28d. Describe			pecify) HOSPICE
On Iding	eune	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D.		Know (	28c. fnjury Work?		1011		000101	1
Division of Vita I or Attending Physicien: efter death.	by the	Ifica	3 Suicide 6 Could not be	28e. Place of Ir	njury - At home, fa			•	28f. Location (	Street and	Number or	Rural Route Number,
tel or	ui pe	Certification:	4 Tromicide	4.5	etc. (Specify)				35,8	WOOL	tring i	D 212 34
Division of To the Hospitel or Attending Phys within 24 hours effer death. To the Funerel Director: After this:	letely fill	edical	29a. Certifier 1 Certifying Physical Check only one)	sician: To the besiner: On the basis and manners	of examination ar	ge, death o ind/or inves	ccurred at the time stigation, in my opi	e, date and place, inion, death occur	and due to the	cause(s)	and manner	as stated.
To th within	dE 00	Me	29b. Signature and title of certifier	~	1		29c. License			29d. Date	signed (Mo	nth, Day, Year)
•			M. Miller	न्या ८	uty		D180	067		Aug	ust	25,2006
3	0		30. Name and address of person who co	MM A	4 7.	1.1.	- U-11 C.	T. Lutho	nuille !	-	210	93
4 39 34	Sta		31. Date fifed (Month, Day, Year)	32 Regist	trar's Signature	has	84.3		1			)
R	egistr	ar	AUG 2 8 200	State Service	es st	AST FEBRUARY						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Palma Catalfo Month 11:52 AM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mercy Medical Center Baltimore Il Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Director 94 Yrs. 220-38-5604 Sept 8, 1911 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or items 23s or 28s-f show the Medical Examinar must be notified at 1X Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 1004 Fawn Street USA Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☑ No ۾ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 ages 1 and 2 should be filed wi ont of Health and Mental Hygien It: if item 27 is marked other th y or other traumatic event, Its none housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental importent: if item 27 is marked eny injury or other traumatic events. Luca Gramese <u>Antionette DiNenna</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Catalfo/son 817 Vale Road Bel Air, MI) 21014 ce of Disposition (Name of Date 200 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ⊠Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald S Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 my Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock. If heart failure. List only one cause on each line. Interval Between Doset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure hours /Medical Due to (or as a consequence of): Examiner daus prelimonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): Box 68760. signed by the attending physicien be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ha TSello, M.D August 21, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 St. Paul Place, Baltimore, M.D. 21202 Anita Isen 32 Registrar's Signature 31. Date liled (Month, Day, Year) AUG 2 8 2008 State Registrar

06-06344 Larry Lamont Cherry

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 27068

		I- For State Registrar		C	Certifica	ate of i	Death			Re	g. No.	4	UU	0 2/0	J
Physicia	_	Decedent's Name (First, Middle)	dle,Last)						2.	Date of Deat Month	h Day	Year		3. Time of Death	
ledical Examir		LARRY LAMOI	NT CHERRY							August 24	, 2006			1650 hrs	
			Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death University Hospital Shock Trauma  Baltimore								4c. C	ounty of	Death		
	=	Social Security Number	6. Sex	7. Age (In y	re last hist	hdov)	If Under 1 Ye	or If Llade	er 24Hrs.	B. Date of Birt	th/MM/DD	N/F		nplace (State or	_
Funeral Director	ľ	5. Social Security Number		7. Age (in yi		• •		ays Hours		o. Date of bill	u (WIM/DD	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Foreign	1	
Director	ļ	217-56-6073	1 X M 2 F	1	5	66 Yrs.				03/30/	<u> 1950</u>		Coul	ntry)MARYLAND	_
any	}	Usual Residence of Decedent  10a State 10b. County		10c. (	City, Town	or Locatio	n				-			10d. Inside City Limits	-
		MARYLAND N/A	Λ.		DA	LTIM	)DE							1 XYes 2 No	
Maryland 28a-f show d at once,	흸	10e Street and Number	.,		DE		10f. Zip Code			T 10	0g. Citizer	n of Wha	at Count	rv?	П
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vith the M s 23a or 2	<u>ا ج</u>	2023 N. PAYSO		cedent Ever i	n U.S.	13. Was	212 Decedent of H		nin? (Spec	ify Yes or No		.S.P		an Indian, Black,	-
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fter de l'', or		3 Widowed 4 Div	1 Yes	2 <u>x</u> tN ear	0	1 🗆 🔻	res 2 XXN	lo specify:			Sp	ecify.	BLA	CK	
hours af "natural	d p	15. Decedent's Education (Spe	or Dates: cify only highest gra	ade completed			s Usual Occup				16b. Kını	d of Bus	iness/In	dustry	
72 ho n "na al Ex	eted	Elementary/Secondary (0-12)	College	(1-4 or 5+)	7 '	auring mo:	st of working li	re. DO NOT	use retired	)					
036 vithin 72 ene rr than Medical	Comple	12th grade				PAIN	ΓER						'EM	PLOYED	
5-00 iled wit Hygien I other the M	ပိ	17. Father's Name (First, Middle.	Last)					18.Mother	's Name (F	irst, Middle, N	Maiden Su	ırname)			
21215-0036 Uld be filed within 72 Mental Hygiene marked other than " c event, the Medical	Be	RUDOLPH CHI							known						_
D 2 Shouls and M atic e	의	19a Informant's Name/Relations			198		Address (Str								1
nore, MD 21215-0036  ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene 1: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once		Dawn Cherry/Da 20a Method of Disposition	augnter	20	Ob. Place o	2023 of Disposit	N. Pay	rson S	t., B	altimo	20c. Loc	Mary cation - 0	Lane	d 21217 own, State	_
Baltimore, permit Pages I an Department of Hea Important: If iter		1 Burial 2 XX Cremation	3 Removal	from State	cremat	ory or othe	er place)	- 1							
tim trant result		4 Donation 5 Other S		] :	METRO		MATORY		08-2	8-06	BAL	TIMO	RE,	MARYLAND	_
Baltimore permit Pages I Department of E Important: If i		21. nature of Funeral Service	Icensee			WI	LLIAM (	BROW	N COM	YTINUM	FUN	ERAL	HO	ME P.A.	ı
Physician	-	Part I. Enter the discusse, or	complications that	caused the de	eath. Do no						est, shock	, or hear	t	Approximate Interval	
/Medical	/	//	on each line.  a Hypertens	ivo Cardio	vaccula	r Disone	se complie	ated by M	lultinle lr	niuries				Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)		a consequen		Discas	se compile	ated by iv	ranipie ii	ijuries					+
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	iner	if any, leading to immediate cause. Enter Underlying Cause		a consequen	ce of).										
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8760, tificate be ex ng physician as the burial	Me	IF FEMALE: 23b. Was decedent pregnant in t		, outcome of p				. De.				Date of c	-	V	
certificant	iai	past 12 months?	I	birth gnant at time o	~	Feta	er (Specify)	BEctopio	c pregnanc	У	IVI	lonth	Da	ay <b>Y</b> ear	
Box 68 ne death certification to the attendin	Physicia	1 Yes 2 No 9 Un	known 9 Unk	nown		J Our	el (Opcony)								J
Records, P.O. Box 6  The law requires that the death cer cate has been signed by the attendi page 2 should be detached for use		Part II. Other significant condit	tions contributing	to death but r	not resultin	g in the ur	iderlying caus	e given in Pa	art I.	23e, Did to	bacco us	e contrib	ute to th	ne cause of death?	_
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Recol The law cate has	Completed										rmed?	de	eath?		
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of Vital Records, g Physician: The law requir wher this certificate has been s meral director, page 2 should	o Be	examiner?	Hospital: 1	Inpatient 2	ER/0	utpatient	3 DOA	Other <sub>4</sub>	Nursing l	Home 5	Residenc	e 6	Other:		10
J of Jing Plu After t	-	27. Manner of Death	28a. Dat	e of Injury th, Day, Year)		Time of In	ury 28c. Ir	njury at Work		Bd. Describe I ubject fell	how injury	occurre	d		_
Division ral or Attendi rs after death al Director; /	Certification:	1 Natural 5 Pen 2 ✓ Accident Inve	ding Aug 24	th, Day Year) 1, 2006	163	0 hrs	10	Yes 2	No St	abject lell					
Divis pital or At ours after d eral Direct filled in by	tific	3 Suicide 6 Cou	ld not be 28e. Pla	ace of Injury -	At home, fa	arm, street	, factory, office	e building, et	tc. 28	Sf. Location (Sor Town, S		Numbe	r or Rur	al Route Number, City	
Di pital ours ?	Cert	4 Homicide	ermined (Specify	/) Townho	ouse / R	owhous	e		13			on Stre	∍et, Ba	altimore, MD	
Division of Vital F To the Hospital or Attending Physiciau: within 24 hours after death To the Funeral Director: After this certifi completely filled in by the funeral director,			hysician: To the basis												
To th within To th comp	Medical	29b Signature and title of certifications	and manner	stated.	on and/or l	vesiigalli		nse number	ouncu at li						_
	2	July Signature and title of certification	- // -					nse number C.M.E.						th, Day, Year)	
	15	Hantely sulfa	44, MI)					J.IVI. ⊑.		-	Augus	st 25, :			
\	11 9	30. Name and Arrivess of person who completed cause of death (Item 23a) Pamela Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201													
	ate			Registrar's Sig	nature				_, 2						_
Regis				was d	7. 19	porte	!								

			1 - Stata Amend item#19a,p	State of Ma erFH,G858,8/	ryland / I 28/06 TI	Departmo Certific	ent of Hea ate of De	alth and Mo eath	ental Hygie Reg.	ne2006 No.	27069
	Physicia /Medic		Decedent's Name (First, Middle, Last,     BETTY	MARSH	A	COHEN	1		2. Date of Death Month AUGUST	22, 20°06	3. Time of Death 8:35 P M
	Examin		4a. Facility Name (If not institution, give 13 HOLLY COURT	street and number)		4b. C		ocation of Death		4c. County of Deat	rimore
	Funeral Director		Social Security Number 6. Se	7. Age	(In yrs. last bi	rthday) If Ur Yrs. Mont	der 1 Year		8. Date of Birth	9 Birt	hplace (State or Foreign MD
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	vn or Location					10d. Inside City Limits
	a-f eho	ctor	MD BALTIN	10RE	(	OWINGS	MILLS				1 □ Yes 2 X No
	3a or 28	I Dire	10e. Street and Number  13 HOLLY COURT			10f.	Zip Code	21117	10g.	Citizen of What Co	USA
36	s 1 and 2 should be filed within 72 hours after deeth with the Maryland f Heelth and Mental Hyglene. Item 27 is marked other then "natural; or items 23a or 28a-f show other traumatic event, the Medical Establish mail the notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 N Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give X			_	anic Origin? (Spe Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
90-0	72 hour natural	ted b	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad	Year or Dates:	168	a. Decedent's l	Jsual Occupation	on ing most of workin	168	o. Kind of Business	
Maryland 21215-0036	within 7 ene. then "r	Completed	Elementary/Secondary (0·12)	Coflege (1-4or 5-	+) 4	BOOKKEE	Tuse retired)	ing most of working		OVING COM	MPANY
nd 2	id be filed fental Hygie rked other ilc event, II	Be	17. Father's Name (First, Middle, Last)		CCUNE	IDERMAN		8. Mother's Name	(First, Middle, Mai	den Sumame)	VOLKIN
aryla	2 should be and Mental ie marked aumatic ev	<u>٢</u>	ALBERT  19a. Informant's Name/Relationship (T)						l Route Number, C	ity or Town, State, 2	
	1 and 2 Heelth a em 27 ie		CarreyUCK COHEN / HU	SBAND		13 HOLL				MD 21117	
Baltimore,	permit. Pages 1 Depertment of H Important: if ite any injury or ot once.		20a. Method of Disposition  1	1	cemete	URLANDE	or other place) R VERE	IN 08/2	4/2006	ROSEDALE	, MD
Ball	permit Deper Impor any in		21. Signature of Feneral Service Licens	Trus	er		and Address			N & BROS. KESVILLE	., INC. , MD 21208
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Finaf disease or condition	ications that caused ne cause on each lin				such as cardiac o			Approximate Interval Between Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or as a			14 110		1/-		7
	ed sit	lner	Sequentiafly fist conditions, if any, leading to infiniediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	s consequence	ol).					
) O	ficate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	a consequence	of):					
68760,	icate be physici s the bu	edical		d							
Box	law requires that the death certifit as been signed by the ettending t 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deat	h 3 Ectop 5 Other	ic pregnancy (specify)			23d. Date of de Month	livery Day Year
rds, P.O.	w requires that the base of the control of the cont	Ď	Part II. Other significant conditions co	ntributing to death bu	at not resulting	in the underlyi	ng cause given	in Part I.		co use contribute to	o the cause of death?
of Vital Records,	The ete h page	Completed							24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
Vita	Physicien: T this certificet rat director, pa	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospitaf:	nt 2□ER/C	outnetiont 3	DOA Other:		(Check only one)	e 6 □Other (Spe	noihe)
	After		27. Manner of Death  1 Natural 5 Pending  1 Accident investigation	28a. Date of Injur (Month, Day	y 28b.	Time of Injury	28c. Injury a Work?		28d. Describe how		City
Division	al or Attend s after death if Director: ,	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pface of Inju- building, etc	ury · At home, c. (Specify)	farm, street, fa	ctory, office	1	28f. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
	To the Hospital or Atti within 24 hours after de To the Funeral Directs completely filled in by the	edlcal (	29a. Certifier Check only one) Cartifying Phylogen Medical Exam	sician: To the best of inar: On the basis of and manner sta	examination a	ge, death occu und/or investiga	rred at the time, tion, in my opin	, date and place, a nion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and du	s stated. e to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	Any con	en y	0.	29c. License r			B -23	
	io		30. Name and address of person who co	ompleted cause of de	eath (Item 23a	) (Type, Print)	T. BA	27Mod	EMP I	B-23.	
	Sta Regist		31. Date filed (Month, Day, Year) AUG 2 8 2	32. Registra	ar's Signature	Spen	a la				

State of Maryland / Department of Health and Mental Hygiene 20061 - Stete Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 23, 2006 Month **Physician** Derendea amphor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner Good Samaritan Baltimore Hospital If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, 12-31 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours LOT Yrs. 219.26.5766 1 □ M 2 💢 F MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland enert of Health and Mental Hygiene and it if Itam 27 ie marked other then "neture!", or Items 23e or 28es's ehow and it if Itam 27 ie marked other then "neture!", or Items 23e or 28es's ehow any or other traumatic event, the Medical Experiment must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Baltimore Be Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21212 Road 1.050 Cameron 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 MNo 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Yes. Give Specify: Black 3 XWidowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland 12th grade river 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harris reola Walter ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Bautimore MD 21212 1050 Cameron Road amanter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation permit. Page Department of Important: If any injury or once. Cedar Hill Cemeter 08.29.06 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) nd Address of acility from Funeral Services York Koad Baltin Pore ND 21212 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardio **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) ed by the detached Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this haral Director: After the filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Natural 2 Accident 5 Pending within 24 hours effer death.

To the Funaral Director: All completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖄 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier K. 90 Schudely - Physician 8-25-2006 D39758 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9114 Philadelphia Ro Suite 300 BACTO MD 21237 Keuin G. Schendel MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

AUG 2 8 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 006 27071 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month Day Yeer 9:37 Physician Sylvester 2006 20 oleman MILTON /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Neme (If not institution, give street and number) Examiner Batti more
If Under 1 Year | II Under 24 Hrs. NIA Memoria Union HOSPITAL Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, 5 - 29 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 XM 2 ☐ F 213-30-8588 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f ahow the Medical Examiner must be notified at ↑Yes 2 No Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1604 21202 USA 14. Race - American Indian, Street or Items 23s Funerai Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. 11. Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: Black þ 3 Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Enoch Pratt Library 12 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) should be fi Be Sr. Ida eman 101 19b. Mailing Address (Street and Number or Rural Route Number, City Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Ia rr any injury or other traum once. Balto Scott-Street Md H.5 1604 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison -28-06 DWINGS 4 ☐ Donation 5 ☐ Other (Specify) rocest 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Philip A. Weather Ford Funeral Home 2431 E. Oliver Street Balto. MD 21213 Gulp 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ntruccan /Medical Due to (or as a consequence of): Examiner siration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence ol) Examiner the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ō in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗙 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

been signed by should be detac Division of Vital Records, page or Attending Physician: rector. funeral dir After death.

Completed by Be 2

within 24 hours after death To the Funaral Director: completely filled in by the

Certification: Medical

State Registrar

31. Date liled (Month, Day, Year)

29b. Signature and title of certifier

25. Was case referred to medical

5 Pending

investigation

6 Could not be determined

Jalul

1 Yes 2 No

examiner?

27. Manner of Death

1 Natural
2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 🗍 Homicide

WALEED



M.O.

1 Inpatient

28a. Cate of Injury (Month, Day Year)

MID #0872

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)

28b. Time of

Injury

29c. License number T2438941

Other:

1 Yes 2 No

28c. Injury at Work?

3 DOA

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 08/20/2006

1 ☐ Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E-University Purkway Memorial Hospital Baltimore

28f. Location (Street and Number or Rural Route Number, City or Town, State)

autopsy

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

1 Yes

26. Place of Death Check on one

performed? Yes 2 X No

28d. Describe how injury occurred

AUG 2 8 2006

BOLAD



To the Hospitel

			For State Registrar	State of Marylan	d / Depa		lealth and M	lental Hygie	_	27072
	Physici /Medic	al	1. Decedent's Name (First, Middle, La			DE	NCSY	2. Date of Death Month AUGUST	Day Year 7 24 200	3. Time of Death 6 9-20 PM
) 	Examin Funeral Director	ier	4a. Facility Name (If not institution, given the South NS 5. Social Security Number 6.5 216–14–0720	HOPKINS HO		-	Location of Death TIMORE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y. December 2.	9. Bi	Thplace (State or Foreign ountry)
Baltimore, Maryland 21215-0036	Maryland n-f ahow iling at	by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland N/ A		o, Town or Loc					10d. Inside City Limits 120  120  100  100  100  100  100  100
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Department: If them 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic evant, the Medical Examinar must be notified at once.		10e. Street and Number 6824 Eastbrooke Avenue			10f. Zip Code 21224			10g. Citizen of What Country? USA	
			11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2X No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	te, etc.
		Completed	(Specify only highest grade completed) (Give life. L. Elementary/Secondary (0-12) College (1-4or 5+)			dent's Usual Occupation kind of work done during most of working DO NOT use retired) USEWI fe			Own Home	
	uld be file Mental Hy, srkad othe	To Be (	17. Father's Name (First, Middle, Last John Ciocca	)			18. Mother's Nam Agnes Ma	e (First, Middle, Ma agnolia	den Sumame)	
	l end 2 sho feelth and I im 27 is ma har trauma		19a. Informant's Name/Relationship ( Richard Joseph De	encsy son	6736 1	-	zenue, Du	al Route Number, Condalk, Mar	yland 21	222
	t. Pages 1 riment of H rient: If Ita rjury or oti		20a. Method of Disposition  1 Paurial 2 Cremation 3 S  4 Donation 5 Other (Special Service Lice	Removal from State Sacr	emetery, crem ed Heart	of Jesus	Oem. Augu 20	06 E	undalk,	Maryland
Ba	Depa Impo any I		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222  23a. Part 1. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate Interval Between Interval Between							
	Physician /Medical	Certification; To Be Completed by Physician/Medical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.  RESPIC  Due to (or as a consequence)	LATOR			,		Interval Between Onset and Death 30 MINUTES
	icate be executed physicien and physicien and sthe burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							2 days MONTHS
	The law requires that the death certificat is the has been signed by the ettending phy page 2 should be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	ant 23c. If yes, outcome of pregnancy					23d. Date of delivery Month Day Year	
	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?  1  Yes		
	the Hospital or Attending Physician: At A hours after death.  the Funerel Director: After this certification in the funeral director; it is a fine to the funeral director; it is a fine to the funeral director; it is a fine fune funeral director; it is a fine funeral director; it is a fine funeral director; it		25. Was once returned to medical					topsy prior to completion of cause of death?  22⊠No 1 ☐ Yes 2 ☐ No		
			25. Was case referred to medical examiner?  1 Yes 2 2 2 2 2 2 3 2 3 2 3 2 3 2 3 3 3 3 3							ecify)
Division			Tagratulal S Teliding				k? Yes 2□No	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		Medical C	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
)	T V With	2	29b. Signature and title of certifier  FURTHER  29c. License number  PES-000 AUGUST 24 2006  30. Name a life address of person who completed cause of death (Item 23a) (Type, Print)  TOSEPH FUENTES 600 NORTH WOIFE STREET BALTIMORE MARYLAND 2128+							
ľ	)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JOSEPH FUENTES 600 NORTH WOIFE STREET BALTIMORE MARY LAND ZIZE  State 31. Date filled (Month, Day, Year)  32. Registrar's Signature								
	Registr		31. Date filed (Month, Day, Year) AUG 2 8 2006  32. Registrar's Signature							

		1 - State Registrar					uncai	te of C	Jeani		Reg.	NO.		
hysici	an	Decedent's Name (F		<b>S</b>		10				2. Date o Month		Day	Year	3. Time of Deat
/Medic		Stei	sen	Da	w	140				Augo			2006	1:30 p
xamin	ier	4a. Facility Name (If no		e street and number)					Location of Dea				ty of Death	
		5. Social Security Number				ast birthday)		r 1 Year	If Under 24 Hr	•			time	
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			b. County		10c. City	, Town or Lo	cation						1	0d. Inside City Lin
	0	Maryland	Baltim	ore		Reiste	ersto	างกา						1 Yes 2
E H	Director	10e. Street and Numbe						p Code			10a	Citizen of	f What Coun	ntry?
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is marked other than 'natural, or itema 23a of 28a 1 enow raumatic event, the Medical Examinar must be notified at	by Funeral	1 Never Married		Armed Forces?  Yes 2  If Yes, Give  Year or Dates:			fYes, spe 1 □ Yes		Specify:	rto Rican, etc.	)	Spec	ack, White,	etc. nite
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the state of the s		20a. Method of Disposi			20b. Pt	lace of Dispos	sition (Na	me of	·	Date	-		- City or To	wn, State
0.0				Removal from State		emetery, cren tro. Gre			ng. 28,2	2006				
		4 ☐ Donation 5 [ 21. Signature of Funer			1100				s of Facility	_000	Da	- C - III	010, 1	14.6
Important: If item 27 is marked eny injury or other traumatic ev once.		. 4 ./	Ell s			Eg	khar	dt F	ineral (	Chapel	P.A.	c Mi	11c N	ld. 2111
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ician dical niner		fmmediate Cause (Fin disease or condition resulting in death)	ailure. List only	one cause on each l	ine.	n. Do not ente	er the mod	de of dying		c or respirato		,b MI	1	Approximate Interval Between
ician dical niner	ai Examiner	shock, or heart fa fmmediate Cause (Fin disease or condition	ailure. List only al  tions, scriate ng	one cause on each l	SWO	n. Do not ente	er the mod	de of dying	, such as cardia	c or respirato		,5 MI	1	Approximate Interval Between
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DHMH 17 Rev 1/2001

	4	For State Registrar	State of Maryland		rtment of F		R	eg. No U U	
Physicia /Medic	ai -	1. Decedent's Name (First, Middle, Last Thomas B. Ferkler,	3rd				2. Date of Deat Month AUGUST	,26,200	
Examin	er	4a. Facility Name (If not institution, give  LEVIN DALE  5. Social Security Number 6. Se		at hirthday)	4b. City, Town, o  Baltimor  If Under 1 Year	r Location of Deal	8 Date of Birth		nore City
Funeral Director		216-16-4304 10 Usual Residence of Decedent	XM 2□F 84	Yrs.	Months Days	Hours Min	Jan. 2	4,1922 N	laryland
e Marylan Ba-f ehow	ctor	10a. State 10b. County  Maryland Anne Arun		Burni	Le			log. Citizen of W	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
3a or 2	Dire	10e. Street and Number 1122 Nottingham Dr	ive		10f. Zip Code 21061			United S	•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merial Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a or 28a-f show emportant: If item 27 is marked other than "naturel", or itema 23a or 28a-f show empirity or other traumatic event, Ite Medical Examinar must be notified at once.	by Funeral Directo	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 (25 ves 2 □ No If Yes, Give Year or Dates: WW II	11	Vas Decedent of H f Yes, specify Cub ☐ Yes 2 1 No	lispanic Origin? (San, Mexican, Puel Specify:	Specify Yes or No- to Rican, etc.)	Black	- American Indian, , White, etc. White
thin 72 hour e. an nature! Wedical Ex	Completed b	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give . lite. [	lent's Usual Occup kind of work done OO NOT use retired	during most of wo d)		16b. Kind of Bus	siness/industry
filed will Hygien ther th		17. Father's Name (First, Middle, Last)		[nsta]	llation &		me (First, Middle,	Communic Maiden Sumame	
Aental rked o	To Be	Thomas B. Ferkler,	Jr.			Edith	Mae Lew	in	
12 sho nand h risma rauma	i d	19a. Informant's Name/Relationship (7			•		Clon Burn		State, Zip Code) :y1and 21061
Pages 1 and ent of Healt nt: If item 2: ry or other 1	199	Stephen M. Ferkler  20a. Method of Disposition  1 🛎 Burial 2 Cremation 3 Comparison 5 Other (Specify	20b. Pla cen Removal from State	ce of Dispo	sition (Name of natory or other pla	ce) Aug	Date gust 30	20c. Location - (	City or Town, State
permit. Departm Importa eny inju		21. Signature of Funeral Service Licen	1000	K3 42	Name and Addre Lrkley-Ru 21 Crain	ss of Facility iddick Fu Hwy., S.	neral Ho E., Glen	me, P.A. Burnie,	MD 21061
Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. CONGESTIVE	HE		ng, such as cardia		rest,	Approximate Interval Between Onset and Death
/Medical Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque  LARYNGE  Due to (or as a conseque  c.  Due to (or as a conseque  d.	PAC ence of):	CARC	NOMA			
death certifi e attending id for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnan  1 Live birth 2 Fetal of  4 Pregnant at time of dea	death 3	Ectopic pregnanc Other (specify)	у		23d. Date Mon	e of delivery tth Day Year
8 5 0	d by Ph	Part II. Other significant conditions of	· ·	ting in the u	nderlying cause gr	ven in Part I.			ibute to the cause of death? 3□ Probably 4 ŻÜnkno
elaw hasb ge 2 s	complete						24a. Was a autop perfor 1 Tyes	rmęd? d	Vere autopsy findings availa rior to completion of cause ( eath? Yes 2 \( \) No
Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ot	her	eath (Check only or		
ding Phys The After this funeral dis	ation: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	R/Outpatier 28b. Time o Injury	f 28c. Inju	4   140131119	Home 5 Resid	now injury occurre	
al or Attendests after death	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, sti	reet, factory, office		28f. Location (S City or Tow		er or Rural Route Number,
o the Hospital	edical C		ysician: To the best of my knowniner: On the basis of examination and manner stated.				curred at the time,	date and place, a	and due to the cause(s)
To the within 2.	¥	29b. Signature and title of certifier  Alexander 14.	hirpothine		29c. Licen	se number 63327		,	1 (Month, Day, Year) 2/2006
0		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)				
Sta Regist		31. Date filed (Month, Day, Year) AUG 2 8 2	06 Segues A	F By	soll				

State of Maryland / Department of Health and Mental Hygiene 2006 27075 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Year Beverly Fryza AUGUST 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Franklin Square Rosedale
If Under 1 Year If Under 24 HOSPIta 8. Date of Birth (Month, Day, Year) March 15,1936 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🕏 F Maryland 216-32-0005 70 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or Iteme 23a or 28e-f ehow vent, the Medical Examinar must be notified at 1 ☐ Yes 2 TNo Maryland Baltimore Essex Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 United States 1027 Foxwood Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Press Operator National Can Co. 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked Lillian Kappel Richard F. Kilmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: if item 27 is any injury or other trau (Husband) Mr. Bernard Fryza 1027 Foxwood Lane Essex, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/25/2006 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation / 5 ☐ Other (Specify) 21. Sign ture Funeral Service Licens Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wis**e** Ave. Dundalk, Maryland 21222 Parti. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage
Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, and bearing to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consumency of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. .O. Box 68760, Due to (or as a consequence of): by Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Records, P. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l certificate 1 🗆 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient ٩ 2 ER/Outpatient 3 DOA this Director: After that in by the funeral 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funerei C pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063974 30. Name and address son who completed cause of death (Item 23a) (Type, Print) Sriramy-tadmaNABITAN 9000 Franklin Square Drive 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2006 27076 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Donald Fay Foley August 26, 2006 4:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center For Hospice Baltimore Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**№** M 2□ F Yrs. 220-30-0899 Director West Virginia June 7,1934 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show I Hygiene. other then "naturel", or iteme 23a or 28a-f ehov vent, itte Madical Examinar must ke notified at 1 ☐ Yes 2 ☑ No Maryland Baltimore Director Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Transverse Avenue 21220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1XXes 2 □ No
If Yes, Give
Year or Dates: Korea within 72 hours after 1 ☐ Never Married ŽOMarried Maryland 21215-0036 1 ☐ Yes 2XXVo Specify: 2 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor General Motors 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked oth any linky or other traumatic event potes. Be John Grover Foley Louie Jane Conrad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loretta Foley (Wife) 3 Transverse Avenue, Baltimore, Maryland 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State D☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard. Aug. 28, 2006 Faltimore, Maryland <sup>22. Name and Address of Facility</sup>
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Extend the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ears **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown as been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s cartificete has lirector, page 2 2 No 1 ☐ Yes or Attending Physician: : Aftar this cartification, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. Director: / 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funarai C completely filled is filled Hospital 29a. Certifier to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29b. Signature and title of certified 29c. License number th (Item 23a) (Type, Pript) Charles St. Boltimone, Md 6701 . Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 8 2006 Registrar

			For State Registrar		State of Ma	ryland /		irtment d <i>tificate</i>			lental Hy	giene Reg. No.		0	2/0	11
			Decedent's Nam	ne (First, Middle, Las	t)	-	-	-			2. Date of De	aath Day	/ Yea	.	3. Time of Dea	
	Physicia /Medic		Margaret	t Elizabet	th Glantz						Augus	r 23	2001	0	9.451	2 M
	Examin	er	4a. Facility Name (	'If not institution, give	street and number)			4b. City, To	own, or Loc	ation of Death			County of De			
			5. Social Security N	ELOPSHANG Number 6. Se	TON ME	(In yrs. last b	ENU	If Under 1	JEN Year III	Under 24 Hrs.			HHE !			<u> </u>
	Funeral Director		219-28-19	905		73	Yrs.			ours Min.	8. Date of Bir (Month, Da April	19,			e (State or Fo 1 1and	n eigi i
and	A 11		Usual Residence o 10a. State	10b. County		10c. City, Tox	wn or Loc	cation						10d.	Inside City L	imits
Mary	a or 28a-f ehow be notified at	ğ	MD	Anne	Arunde1	Pasa	adena	a							1 🗆 Yes 2	₩ No
the the	r 28a	Director	10e. Street and Nu	impet				10f. Zip Co	code			10g. Citi	izen of What	Country	?	
E W.	23a o		4338 Mou	ntain Rd				2112	22			IIn	ited S	tate	25	
r dee	E E	Funeral	11. Marital Status		12. Was Decedent 8 Armed Forces?		13. V	Vas Deceder Yes, specify	nt of Hispar y Cuban, M	nic Origin? (Spelexican, Puerto	ecify Yes or No Rican, etc.)		14. Race - An Black, Wh	nerican	Indian,	
72 hours after deeth with the Maryland	el', or it	þ	1 ☐ Never Marr 3 ☑ Widowed	ried 2 Married 4 Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo		☐Yes 2፟⊠		pecify:				Whi		
72 ho	netur	eted	(Spec	15. Decedent's Ed	lucation de completed)	16	(Give )	lent's Usual (	done during	g most of work	ng	16b. Ki	ind of Busines	s/Indus	itry	
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2 should	oith and Mental Hygiene. 27 is marked other then r traumatic event, the Mi		19a. Informant's N	lame/Relationship (7	Type, Print)	19	b. Mailin	g Address (S	Street and I	Number or Rura	A Route Numb	er, City o	r Town, State	, Zip Co	ode)	
and	m 27 her tr			pson / da	ughter					<u> </u>						
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permit.				uneral Service Licen	·	-	22	. Name and	Address of	Facility Amb	rose Fu	ınera	1 Home	, I1	nc.	
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	nysician Medical		disease or condition resulting in death)	on	a. Due to (or as a	D VAS	SCH C	AI<	Acu	DENT		-		-		
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he dee	ed by the atte	Physician/M	in the past 12 1 ☐ Yes 2 9 ☐ Unknowr	□No	4☐Pregnant at 9☐ Unknown			Other (spec		<del></del>			Month	Da	ıy Yea	r
s thet	igned by be detac	by Ph	Part If, Other signi	ificant conditions c	ontributing to death bu	ut not resulting	in the un	nderlying cau	ıse given in	Part I.	23e. Did	tobacco u	se contribute	to the	cause of deat	th?
aguire	been sig should b										10	Yes 2	□No 3□	Probab	y 4 🗷 Unki	nown
The faw requires thet the deeth cert	sete hes be page 2 sh	Completed									24a. Was		24b. Were prior to death	o comp	findings ava	ılable e ol
		e Co	25. Was case refe	rred to medical						Place of Death	1 Yes	2 No		es 2(	□No	
Vsici	r this certific	0	examiner? 1 ☐ Yes 2 ☑	/	Hospital: 1 Inpatie	nt 2 ER/C	Outpatien	t 3□ DOA	Other	Nursing Ho			6 ∏Other /Sr	necifu)		
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the Hospital or Attending Physicien:	within 24 hours efter death. To the Funerel Director: A completely filled in by the fu	Medical (	29a. Certifier (Check only one)	1 ☐ Certifying Ph 2 ☐ Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examination a	ge, death and/or inv	occurred at restigation, in	the time, d	late and place, n, death occurr	and due to the	cause(s) date and	and manner I place, and d	as state	ed. e cause(s)	
Total	vithi To ti	M	29b. Signature and	title of certifier	)	WAL	\	29c. L	License nur			10d. Dat	te signed (Mo	nth, Da	y, Year)	C
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2006 27078 For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** August 26, 2006 6:18 Henry William Gittings /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Center For Hospice If Under 1 Year It Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 120M 2□ F Director 12/12/1928 Maryland 215-22-6247 Usual Residence of Decedent 10d. tnside City Limits 10a State 10b. County 10c. City, Town or Location or 28a-f ehow notified at 1 Yes 2000 Directo Middle River Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Patrial in Item 27 is marked other then "natural", or itams 23a or any highry or other traumatic event, the Medical Examinar must be a once. U.S.A. 21220 119 Riverthorn Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 O.E. 11. Maritat Status 1950tyElYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 200 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X2 ☐ No Specify: Specify: White Completed by 1951 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) 5+ Police Chief Steel Mill 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Leoma Scheidt William H. Gittings ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 119 Riverthorn Road, Baltimore, Maryland 21220 Dorothy Mary Gittings (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩₩Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gard. Aug. 29, 2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signator of Suneral S. Lvice Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) UNU CANCER month Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine inding physicien end use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy
1□Live birth 2□Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death tnjury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of tnjury - At home, tarm, street, factory, office building, etc. (Specify) 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifier no who completed cause of teath (Item 23a) (Type, Print) V. Charles St. Balto Md 2120x BINC 31. Date filed (Month, Day, Year) 32. Amistrar's Signature State Registrar AUG 2 8 2006

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** LINWOOD HARGROVE **⊿**uuus 0640AM ugust 207006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltmore Baltmore HOSP: tal of NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**⊠**M 2□F 237.62.5554 62 Yrs. ÑC Director Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 **⚠** Yes 2 □ No MD NA BALTIMORE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2904 N. WUDON AVENUE 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 KYes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+)
2 YRS SUPERVISOR BAUO. CITY 12 TH GRADE other Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Heelth and Mental H ant: If item 27 le marked ott JULUS HARGROVE CHANNIE KEARNEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BETTY PAIGE - HARGROVE 2904 N. LOUDON AVE. BALTO. MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Dáte 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If eny injury or once. ARBUTUS BAUTMORE 4 ☐ Donation 5 ☐ Other (Specify) 08.26.06 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service Licensee auchn 5151 BAUTO, NATU PIKE, BALTO, MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GI blead **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included events and the cause (Disease or injury) Due to (or as a consequence of): Examiner The law requires that the death certificate be executed nding physicien and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Minknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificete 1 Yes 2 No or Attending Physicien: After this certifice funeral director, p 25. Was case referred to medical Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred n Natural 2 ☐ Accident 5 Pending death. 1 ☐ Yes 2 ☐ No nours after death. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in time certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) BS9316527 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2006 27080 For State Registrar Certificate of Death 1-Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Physician 24, 5:30 A<sup>M</sup> Hunt August 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Co. Edgemere 7604 North Point Road Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 F Yrs Sept. 28,1916 Maryland 89 Director 218-03-1013 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a State 10b County or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Edgemere Baltimore Maryland 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number United States 21219 7604 North Point Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after ☐Yes 2€No fYes. Give 1 Never Married 2 Married White Maryland 21215-0036 1 Yes 2 No Specify: Specify: ģ 3 ₩idowed 4 Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiane. College (1-4or 5+) Elementary/Secondary (0-12) Hutzlers Clerical 12 Years Pages 1 and 2 should be filed w treen of Health and Mental Hygia tant: if tem 27 is marked other to jury or other traumatic event, ID 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lottie Moffit Herbert Elways 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 7463 Lawrence Road Dundalk, Maryland 21222 Mr. Gary Hunt (Son) Baltimore, Date 20c. Location · City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ¥⊠Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. Elkton, Maryland Leeds Meth. Church Cem. 8/28/2006 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eshive DNO mon **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Completed by Physician/Medical as ettending I IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director; After this certifica completely filled in by the funeral director. 26. Place of Death (Check only only) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 22No 1 Tes 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c Injury at Work? Certification; 1 atural 5 Pending 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dev. Year, 29c. License number 29b. Signature and title of certifier MI 45103 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mune 566 100x+ U 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 27081 1 - For State Registrat Reg. No. Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Howard 06 5:10 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Edgewood Md 21040
H Under Year H Under 24 Hrs. 8. Date of B Smoth care du Edierle Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min Months 276 26798 1 □ M 2 N F SY Yrs. OH 10/24/192 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits If item 27 is marked other than "natural", or itams 23a or 28a-f show or other treumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 🛣 No Director MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 W. Heather Road 21014 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 le marked other than "natural", or Itan eny injury or other treumatic event, the Mudical Exer 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: ģ 3 XWidowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 piano teacher church 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jonathan Savre Christie Laura Klein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Knapstein/daughter 110 W. Heather Rd. Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☑Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Funeral Service Licensee Ronald S. Wade ar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, than tailure. List only one cause on each fine. Approximate Interval Between Onset and Death 23a. Part1. Ent shock, or I Immediate Cause (Final disease or condition resulting in death) Branners Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the attending physicien and shed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day signed by the at d be detached fo 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No Division of Vital Records. P.O. 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ZNo 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 22 No 1 Yes 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartification plant of the funeral director ompletely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2XNo 1 Inpatient 2 ER/Outpatient 1 Tyes 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 
Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D28489 8/21/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fleta H. Sckal Wo Bel Air No 206 Hays St 21014 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar AUG 2 8 2006

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle Last Month Day Year 5,00 a M **Physician** 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give Examiner 9. Birthplace (State or Foreign 1 Year Days (rs. last birthday) If Under 1 **Funeral** Months Director Usual Residence of Decedent 10c. City Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. Count d 2 should be filed within 72 hours after death with the Marylan Ith and Mental Hygiene.
77 is marked other then "natural", or Items 23s or 28s-1 show traumatic event. The Medical Examinat must be rediffied at 1 TVes 2 No Funeral Director 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2. If Yes, Give Year or Dates: 2 100 Baltimore, Maryland 21215-0036 Specify. Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) rst. Middlel Maide 18. Mother's Name Pages 1 and 2 s ment of Health ar t of Health a othert Method of Disposition 1 Burial 2 Cremation ŏ Department of Importent: If eny injury or one. 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ornce **Physician** /Medical Due to (or as a codsequence of): Examiner Obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the sahould be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ₱ Probably 4 □Unknown Ji brillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2-8 No 26. Place of Death (Check only one) director, 25. Was case referred to medical Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Tes 2™ No 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Matural 5 Pending To the most after death.

Youthin 24 hours after death.

To the Funeral Director: After the funeral py the fune 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifier Mucs 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 8 2006 Registrar

Keith J. Horton 06-06330

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Baltimore, permit. Pages 1 at Department of He Important: litte injury or other tr	21. Signat	e of Funeral Service Lies	see		22. Name	and Address of Facilit	y 270	Fred It	icron	Pass leto, ndizizza
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	29a. Certific (Check only one)  29b. Signat	er 1 Certifying Phys	ner: On the basis of ex	camination and/or	eath occurred investigation,	at the time, date and pi in my opinion, death o	lace, and due to the courred at the time	e cause(s) and date and plac	manner as sta e, and due to t	rted. he cause(s)
To T	29b. Signat	ture and title of certifier	and manner state	0		29c. License number	r	29d. D:	ate signed (Mo	onth, Day, Year)
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obend		and address of person wh			444.5	n Chrock Dalking	ro MD 24204			
Υ			Assistant Medic	al Examiner	111 Pen	n Street, Baltimo	re, MD 21201			
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	/Medic		Raymond Odin Hanssen					August	7		3:36	Ам
	Examin	er	4a. Facility Name (If not institution, give street and n	•		4b. City, Town, or	Location of Death		4c. County Balt:			
	Funeral		Gilchrist Center For Ho  5. Social Security Number 6. Sex		. last birthday)	TOWSON If Under 1 Year	if Under 24 Hrs.	8. Date of Birth (Month, Day,			place (State ontry)	or Foreign
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pu	*		Usual Residence of Decedent  10a. State 10b. County	100.0	ity, Town or Loc	ation				1,	IQd. Inside Ci	ity Limits
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should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 Never Married 2 Married 1 Yes, 0 3 Widowed 4 Divorced Year or	2⊠No live Dates:	1	☐ Yes 2√ No	Specify:		Specify	w Whi	te	
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shoul	nd Me mark	욘	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	g Address (Street a				State, Zip	Code)	
and 2	alth a		Mary M. Wehmer (Daughte	r)	4220 1	Piney Gro	ve Road,	Glyndor	, Mary	land	21071	
Pages 1 and	of He If item or oth		20a. Method of Disposition  12○Burial 2 □ Cremation 3 □ Removal from	I .	Place of Dispos cemetery, crem	sition (Name of natory or other place	9)	Date	20c. Location -	City or To	own, State	
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ding C	h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	e of Injury nth, Day Year)	Injury	28c. Injury Work		200. Describe no	ow injury occur	100		
Atten	ector: ector: by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Pla	ce of Injury - At ding, etc. (Spec	home, farm, stre	eet, factory, office		28f. Location (Si City or Town		er or Rura	al Route Num	iber,
	rs afte al Dir	Cert										
e Hosp	within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	edical	29a. Certifier (Check only one)  1 ☐ Certifying Physicien: To to 2 ☐ Medical Examiner: On the and ma	ne best of my kr basis of examir nner stated.	nowledge, death nation and/or inv	occurred at the tim estigation, in my op	e, date and place, inion, death occurr	and due to the cared at the time, d	ause(s) and ma ate and place,	anner as s and due to	tated. the cause(s	ş)
Toth	To th comp	Me	29b. Signature and title of certifier	0.	11-0	29c. License			9d. Date signe			00/
. 1)	1		30. Name and address of person who completed ca		em 23a) (Type, F	D25	1 0	0 0	1090	31 0	2,00	
10			W. A. Riley GB			V. Char	les It.	Balt	) Md	210	20%	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 8 2006	Registrar's Sign	A Second	ALL I						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2006 27085 1- semend #18 Per FH G858 8/31/06 JiCertificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:34 P. 25,2006 Kowalczyk August Agnes Mary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 1906 Andrea Finksburg

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Court Carroll County 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 200 215-01-9745 Director 87 Feb18.1919 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Work** r than "naturel", or items 23a or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 No Md. Carroll County Finksburg Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1906 Andrea Court 21048 USA Funeral or items Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√€ No Specify: White Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 8th traumatic svent, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic svent Be John Piechocki Angela <del>Winska</del> Iwinska 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard A. Kowalczyk (son) HC60 Box 141G Slanesville, W.V. 25444 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus Aug 29,06 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facilitaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CUNDID Immediate Cause (Finat disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Due to [or as a consequence of] Examiner if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Il-transit The law requires that the death certificate be executed Due to (or as a consequence of): physicien a the burial-1 Box 68760. Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f Division of Vital Records, P.O. 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1□ Yes 2√ No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending Injury within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel ical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 35 39 completed cause of death (Item 23a) (Type, Print) 30. Name and 555 Su uth Center Street Westminster, MD21157 Books 2. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 2 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 27086 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ÄÜĞUST 23, 2006 MARGARET ANN KLEIN 10:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4730 ATRIUM COURT #360 BALTIMORE OWINGS MILLS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) 07/23/1911 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 95 579-36-9222 Yrs. W۷ Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23a or 28a-1 show eny injury or other traumatic event, the Madical Exeminar recover. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE OWINGS MILLS Completed by Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's USA 21117 4730 ATRIUM COURT #360 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 💢 No Specify Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FRIEDMAN **FEINSTEIN** BAILEY WILLIAM 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4730 ATRIUM COURT #360 - OWINGS MILLS, MD 21117 SHELDON KLEIN / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Nemoval from State BNAI JACOB ETERNAL HOME 8/25/2006 S.CHARLESTON, WV 4 □ Donation 5 □ Other (Specify) 21. Signature of Fort Sarvice Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PI

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio Thrombotic event **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-trensit or Attending Physicien: The law requires thet tha death certificate be executed Division of Vital Records, P.O. Box 68760, $\overset{\sim}{\mathcal{U}}$ resulting in death) Last Due to (or as a consequence of) Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unkaown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 2 10 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA funeral 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Unatural 5 Pending Injury after death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗆 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funarai 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00057465 0, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 Mainst, Suite 700, Reistristown, MO. 21136 N. S. Rajapaksenin Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 2 8 2006

State of Maryland / Department of Health and Mental Hygien 2006

Certificate of Death 27087 2. Date of Death I. Decedent's Name (First, Middle, Last) **Physician** 26, Paul Harry Lample August 2006 11:05A<sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2265 Golf View Lane Carrol1 Hampstead 8. Date of Birth (Month, Day, Year)
Dec. 7, 1926 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X**XM 2□ F 217-22-7428 79 Yrs. Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County I7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examination must be molified at 1 Yes XXNo Director MD Carrol1 Hampstead 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2265 Golf View Lane 21074 U.S.A. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) s 1 and 2 should be filed within 72 hours after ( I Health and Mental Hygiene. Item 27 is marked other than "natural", or Itel XIXIYes 2 No If Yes, Give Year or Dates: WW II 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Government Elementary/Secondary (0-12) College (1-4or 5+) 10 Bookbinder Printing Office 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gertrude Amelia Clatchy Louis Lample ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paula Gardner / Daughter 2265 Golf View Lane; Hampstead, MD 21074 20b. Place of Disposition (Name of competery, crematory or other place)
Lake View
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of He
Important: If iter
any injury or oth XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/30/06 Sykesville, MD 21. Signature of Fureral Service Licensee 22. Name and Address of FacilityEckhardt Funeral Chapel P.A. n 11605 Reisterstown Rd. Owings Mills, MD21117 watere 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lung Physician disease or condition resulting in death) Canax /Medical Due to (or as a consequence of), Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medicai as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No ned by the atten detached for u 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Kucwn 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? Yes 2 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) o the Hospital or Attending Phithin 24 hours after death.
o the Funeral Director: After the propletely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D15552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Crossmonds Dr. Stets40 Owings Sain 172 Howard m. D 23 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygien 2006

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Year **Physician** ames 5:10 A. August 24, 2006 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Examiner Morningside Center Anne Arundel Hanover 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 12€3xM 2□ F Yrs. Director 91 138-05-4521 New York Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: if item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits other traumatic evant, the Madical Examinar must be notified at Anne Arundel Completed by Funeral Director Hanover 1 ☐ Yes 2 No Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7548 Old Telegraph Road 21076 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 □XYes 2 □ No 1950—
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€No Specify: White Specify: 3√Vidowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Public Relations Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth McLean Joseph McLean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Gianforte/Daughter 917 Merriweather Way Severn, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Aug. 29, 20c. Location - City or Town, State 1 SpBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation, 5 ☐ Other (Specify) ö permit. Page Department of important: If any injury or once. 2006 New Hampshire St. Vet.Cem. Concord, New Hampshire 21. Signature Auneral Service Licensee 22. Name and Address of Facility

Kirkley-Ruddick Funeral Home P.A.

421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Examiner burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Box 68760, Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ of Vital Records, pe 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 27. Manner of Death Certification: 28d. Describe how injury occurred Manner of De

Natural

Accident Division 5 Pending investigation after death. 1 TYes 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D54413 /wemp person who completed cause of death (Item 23a) (Type, Print)
I. Lee. 300 | 5. Hanover St. Baltimore 30. Nime and address of 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Mooney August 11:03 AM LICICA 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore City The Johns Hopkins Hospital If Under 1 Year If Under 24 H/s.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security N: 197-56-2462 6. Sex 8. Date of Birth (Month, Day, **Funeral** Months 1 M 2 XF 48 Director December 13, 1957 **Phillipines** Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits r than "naturel", or Items 23s or 28s-f show the Medical Examinar must be notified at Pennsylvania 1 ☐ Yes 2 🕅 No Lancaster Lancaster Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 900 E. King Street 17602 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ XNo If Yes, Give Year or Dates: 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Filipino ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mentel Hygiene.
7 le marked other than "n College (1-4or 5+) Elementary/Secondary (0-12) Case Packer Sauder's Eggs traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mentel Important: If item 27 1e marked any injury or other traumatic evone. Asuncion Abarquez Roberto Tabora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1382 E. Oregon Road Litiz Pennsylvania 17543 Robert Mooney Jr. /Husband 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Evans Eagles Cremation Serv. 8/29/06 Leola Pennsylvania 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck Inc. 5305 Harford Road Baltimore Maryland 21214 llo mistrac 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intravascular Disseminated 6 days /Medical Examiner Pseudomonas Urinary Tract Infection Fungemua,
Due to (or 19 a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner been signed by the attending physicien and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 ponths?

1 Pes 2 No 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certification: To Be Completed by 2. No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1, → Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral i 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 🗆 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \( \text{Homicide} \) Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Zhanna Livshits, Mudical Doctor Res - 000 August 24, 2006 Ballimore, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zhanna Livshits, The Johns Hopkins Hospital, 600 North Wolfe Street P 21287 maryland 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature AUG 2 8 2006 Registrar

		1	For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	ertificate of I	lealth and Me Death	ntal Hygier	<b>ZUUU</b>	27090
	Physici	an	1. Decedent's Name (First, Middle, Last, Ruth Uldine M	ills				Date of Death  Month  D  D  D  D  D  D  D  D  D  D  D  D  D	Day Year + 2006	3. Time of Death 2:50 PM
	/Medio Examin	er	4a. Facility Name (If not institution, give Good Saman, t	an Kos		Balt			4c. County of Death	
	Funeral Director			7. Age	81 Yrs.	Months Days		3. Date of Birth Month, Day, Yea 9-13-192	ari Cou	place (State or Foreign intry) inia
	nyland how		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or					10d. Inside City Limits
	with the Maryland a or 28a-f show be not fied at	O	Maryland N/A  10e. Street and Number			Baltimore		100.0	Citizen of What Cou	Yes 2 No
	23a or 2	i Dir	5639 Carter Aven	ш		2121	4		II S A	, .
9	72 hours after death with the Maryland natural; or Itema 23a or 28a-f show Jical Esa Libertmul be notified at	E	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give			ispanic Origin? (Specin, Mexican, Puerto Ri		14. Race - Ameri Black, White,	, etc.
-003	72 hours "natural", dical Exe	ed by	3 ☐Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:	16a. Dec		ation	16b.	. Kind of Business/Ir	
21215-0036	c * B	Completed	(Specify only highest grade   Elementary/Secondary (0-12)   12	le completed) College (1-4or 5		re kind of work done ( . DO NOT use retired Omemaker	ation during most of working d)		Own Home	
	Hygi Hygi other	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name (	First, Middle, Maid	den Sumame)	
Maryland		5	Marvin Wills  19a. Informant's Name/Relationship (7)	voe. Print)	19b. Ma	iling Address (Street	Marga and Number or Rural			ip Code)
			Margaret E. Mill		ter 119	946 Falls	Road C	Cockeyvil	les, Mary	land 21030
Baltimore,	Page: ment o ent: If ury or		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ I  4 ☐ Donation 5 ☐ Other (Specify,		Gardens	of Faith	Cem. 08-28	3 <b>−</b> 2006 B		Maryland
Balt	permit. Departr Imports any inj		21. Signature of Funeral Sance Licens	ee Charles	F. Miner	22. Name and Addre Leonard J.	ss of Facility Ruck, Inc		arford Ro ore, MD 2	
2.1 2.1 2.1			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of		the death. Do not e				The state of the s	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		a consequence of):	Lailure				
-	Examiner	Je .	Sequentially list conditions, if any, leading to immediate	b. Sepsi	\$ a consequence of):					
D.	acuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. C · 1)	iliale	Colitis				135
68760,	icate be executed physician and s the burial-transit	edical Ex	resulting in death) Last	Due to (or as a	a congenue of):					
_			fF FEMALE:	220 If you guttoome	of programmy					
P.O. Box	Attending Physician: The law requires that the death certificath. cleath. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	B Ectopic pregnancy Other (specify)			23d. Date of delik Month	very Day Year
	quires that in signed b uld be deta	by	Part II. Other significant conditions co Pleural effus iou		ut not resulting in the	underlying cause giv	en in Part I.		co use contribute to	the cause of death?
Division of Vital Records,	The law requir ate has been si page 2 should	Completed		,				24a. Was an autopsy performed 1 Yes 2 T	prior to co	topsy findings available ompletion of cause of
Vital	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:		iont 30 DOA Ott	26. Place of Death			
Jol	g Phys er this eral dir	n: To	27. Manner of Death	28a. Date of Inju (Month, Day	ry 28b. Time	of 28c. Injur	4 Nuising Hom	e 5 Residence 8d. Describe how in	e 6 □Other (Specinjury occurred	ufy)
isior	Attending F death. ctor: After y the funer	catio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ury - At home, farm,	M 1 🗆	Yes 2□No	8f Location (Street	t and Number or Ru	ral Route Number
Div	tal or A	Certification:	4 Homicide determined	building, etc		street, factory, office		City or Town, St	iate)	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical			examination and/or		me, date and place, ar ppinion, death occurre			
	To the Within To the Comp	Ž	29b. Signature and title of certifier	Λ1 "	).	29c. Licens	se number	29d.	Date signed (Month	n, Day, Year)
	10		30. Name and address of person who	completed cause of d	eath (Item 23a) (Typ	pe, Print)	10743	δ	104100	<u> </u>
N Is.	1		31. Date filed (Month, Day, Year)		LOCH R	MEN BL	UD. BAL	TrouckE	MDS	21239
	St Regist	ate rar	AUG 2 8 2	008	was A	Soule				

State of Maryland / Department of Health and Mental Hygien 2006 27091 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 20 Day Physician 2006 ROBERT MARTIN 2:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS TIMONIUM BALTIMORE If Under 1 Year II Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months Days Hours 1 X M 2 □ F Yrs. 229-03-8213 Director 89 Dec 20. 1916 VA Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or iteme 23s or 28s-f ahow the Medical Examinar must be notified at 1 ☐ Yes 2x No Director Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 Dulaney Valley Road 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 140-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: δ 3 ☑ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Office Worker Lincoln Life Ins. Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Lee Martin, Sr. Minnie Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .09 permit. Pages 1 and 2 Department of Health a important: if item 27 is any injury or other trai 900. Sherry McCarter/daughter 1823 Savo Ct. Timonium, MD 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ronald 22. Name and Address of Facility State Anatomy Baltimore, MD Board 655 W. Baltimore Street 21201 nn complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease, or complications that caused the or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ears ) ementia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 3 Probably 4 Unknown DISPUSE 1 ☐ Yes 2 🔀 No Ulmonan Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? this certificate 1 Yes 2 No 2 🗷 No Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4- Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 5 KNo 1 🗌 Inpatient 2 ER/Outpatient 3 DOA of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a the Hospital 1 Propression: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d\_Date signed (Month, Day, Year) 29c. License number gnittom 2006 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT, 2300 DULANEY VALLEY ROAD M.D.TIMONIUM, MD 21093 \$2. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

AUG 2 8 2006

AUGUST

MARTIN

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06-06069 Marcus Mapp

P State of M		200	5 270	01					
1- For State Registrar	gistrar Certificate of Death Reg. No.								
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Marcus Ma	арр	Month August 15	5, 2006	100	0940 hrs				
4a Facility Name (if not institution, give street	t and number) 4b. (	City, Town, or Location of Death	4c. Co	unty of Death		$\neg$			
23 Appleseed Lane	Mon	taomen							

		Registrar					Certifica	ate of	Deam					Reg. No.	£ (	JU	, ,	100
Physicia		1. Decedent's Nam	ne (First, Midd	le,Last)								2	. Date of De				3. Time of D	eath
dical Examii	ner	Marcus			Марр								Month August 1	5, 2006	Year 6		0940 hi	rs
		4a Facility Name (	(if not institution	on, give st		ımber)		4	b. City, To	wn, or L	ocation of				. County o	f Death		
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Funeral		5. Social Security I	Number	o. sex		7. Age (III	yrs last birti	luay)	Months		Hours	Min.	o Date of B	ILTO (IMIMA)	DD/YYYY)	Foreign		
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		Usual Residence of	of Decedent						-		1							
any		10a. State	10b. County			10c.	City, Town	or Locati	on							1	10d. Inside (	City Limits
ž .		Manuland	Manhan				0-:+1										1 Yes	2 No
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ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Nu	ımber						10f. Zip 0	ode				10g Citiz	zen of Wh	at Count	'y''	
the a or	<u>ا</u> ة	23 Applese	ed Lane						208	78				Uni	ted St	ates	Americ	a
5-0036 led within 72 hours after death with the Maryland Hygiene other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	a	11. Marital Status		12		edent Ever	in U.S						cify Yes or N				an Indian, B	
or iten	Funeral	1 X Never Marri	ied 2 N	larried	Armed F			If Ye	es, specify	Cuban,	Mexican,	Puerto R	ican, etc.)		White	etc.		
er de		3 Widowed	4 Div	orced If )	Yes Yes, Give Yea	2 X	No	1	Yes 2	. No	specific			- 1	Sponific	D.1		
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hour	B								t's Usual O ost of worki					16b. K	Kind of Bus	iness/in	dustry	
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O3	티	12		2			Stu	udent						Ed	lucatio	n		
othe Nation	اق	17. Father's Name	(First, Middle	Last)	-		•			18	8. Mother's	Name (F	irst, Middle,	Maiden	Surname)			
21215-0036 lid be filed within 72 hours after Mental Hygiene narked other than "natural"; event, the Medical Examiner	Be	Richard Maj	рр							Н	lope] y	n Wil:	son Ugo	rii				
21215-0036 uld be filed within 7 Mental Hygiene marked other than e event, the Medica	P	19a. Informant's N	ame/Relations	ship (Type	Print )		19b	. Mailing	Address				ral Route Nu		ty or Town	. State.	Zip Code)	
O 등 전 등 표		Hopelyn Wi	lson Uao	rii/Mo	other		23	App'	leseed	Lane	Gai	thers	burg Ma	rvlan	d 2087	'8		
ore, ME is 1 and 2 s of Health at If item 27		20a. Method of Dis		J		т	20b. Place o						Date		ocation -		own State	
S S S S S S S S S S S S S S S S S S S			x Cremation	n 3	Removal fr				ner place)	OI COIN	ciciy,		Date	200. 1	_ocation -	City Of 1	own, State	
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uit. I		21 Signature of Fu			,				lame and A	ddress	of Facility			-		,		
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra		X/1-	_	las. 1	16						,	7601	Sandy	Sprip	a Road	سدا ا	n I An	20707
	-	23a. Part I. Enter t		VU VV	tions that a	aurod the	dooth Do so											
Physician /Medical		failure List or				auseu me o	death, Do No	t enter tr	ie mode or	uyirig, s	uch as ca	Tulac of T	espiratory a	nest, sno	ck, or nea	rt	Approxima Between C	
Examiner		Immediate Cause	(Final disease	a Int	raoral Sl	hotgun V	Vound										De	ath
ZXaillillei		or condition resulti	ing in death)	Due	e to (or as a	conseque	nce of):											
.*		Sequentially list co	onditions	b.														
	ē	if any, leading to in	mmediate		e to (or as a	a conseque	nce of):											
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nd				d														
Division of Vital Records, P.O. Box 68760, the Ilospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. The law requires that the death certificate be executed the Funeral Director: After this certificate has been signed by the attending physician and applietely filled in by the funeral director, page 2 should be detached for use as the burial - transit	an/Medical	UNPENDED	)	A	MENDED													
68760, ertificate be ding physici e as the buri	<u>e</u>	IF FEMALE:		1	23c If yes	outcome of	pregnancy							1224	. Date of o	deliven		
5876 rtificate ling phy	칠	23b. Was decedent		h a	Live b		pregnancy 2	Fet	tal death	3	Ectopic	pregnanc	:v		Month	Da	v	Year
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P.O. Box 61 that the death cert ned by the attendir	Physici	Part II. Other sign	ificant condi	tions co			not resulting	in the II	nderlying c	alise on	en in Par	† I	23e Did	tobaccou	use contrib	ute to th	e cause of o	leath?
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Litis dire	0	1 ✔ Yes	2 No	Hos	pital: 1	Inpatient	2 🗸 ER/0	tpatient	3 DO	A O	ther 4	Nursing I	Home 5	Residei	nce 6	Other:		
1 of Vital Records, ling Physician: The law require After this certificate has been si funeral director, page 2 should b	1.	27. Manner of Dea	ith		28a. Date	of Injury	28b. 7	Time of Ir	njury 28	c. Injury	at Work?		8d Describe		ry occurre	d		
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Division tal or Attendii rs after death al Director: A led in by the fu	Ę	3 🗸 Suicide		ld not be	28e Plac	e of Injury	- At home, fa	rm, stree	et, ractory, o	office bu	ilding, etc.	. 2	8f. Location or Town,		nd Numbe	r or Rura	l Route Nur	nber, City
Divi	Certification:	4 Homicide	dete	ermined	(Specify)	Single	Family					23	3 Apples	ed Lar	ne, Gaitl	hersbu	rg, MD	
Hos 24 h Fun tely		29a Certifier 1	Certifying P	hysician:	To the be	st of my kno	owledge, dea	th occur	red at the t	ime, date	e and plac	ce, and di	ue to the cau	use(s) and	d manner a	as starte	d	
To the Hos within 24 h To the Fun completely	Medical	one) 2 🗸	Medical Exa				tion and/or in	nvestigati	ion, in my o	pinion,	death occ	urred at t	he time, date	e and pla	ce, and du	e to the	cause(s)	
To With	Nec	29b. Signature and	tylé of certif		id manner	stated			29c	License	number			29d F	)ate signe	d (Monti	h, Day, Year	1
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		1	WI	720	1	1				O.C.M	I.E.			Aug	ust 16, 1	2006		
2		30. Name and add	ress of persol	who com	pleted dau	se of death	(Item 23a)											
5		Susan Hog	an MD.	Assista	nt Medic	cal Exam	niner 11	1 Pen	n Street	Baltin	nore, M	ID 2120	01					
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State of Maryland / Department of Health and Mental Hygiene 2006 27093 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Dennis 12 38 PM 22 August 2006 /Medical 4a. Facility Name (If not institution, give street and number) or Location of Death 4c. County of Death Examiner Johns HopKins Bal n/a Hospita timore The 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 ☑ M 2 ☐ F 212-56-5729 Usual Residence of Decedent 56 Director Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Pasadena Md Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 USA 7824 June Drive Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner Auto Body permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked other any lighty or other traumatic event SDR. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be June Fitzgibbons William Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Diane Moore / Wife 7824 June Drive Pasadena, Md. 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Bother (Specify Entombment Loudon Park Cemetery 8/26/06 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Loudon Park Cemetery 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Physician /Medical Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death |Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 | Homicide after within 24 hours a To the Funerel [ Medical 29a. Certifier 🛜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of centries 29d. Date signed (Month, Day, Year) M.O. RES-000 August 22 2006

cause of death (Item 23a) (Type, Print)

600 North Wolfe Street, Baltimore, Maryland 21287 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dommen 31. Date filed (Month, Day, Year) State AUG 2 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygien 2006

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		1 - State Registrar		Cer	tificate of	Death		Reg		J ()	21034
у 9	g P	1. Decedent's Name (First, Middle, La	st)				2. Date of	of Death			3. Time of Death
Physic		DIANE LEE N	ADOLSKI				AUG.				9:20 A. M
/Medi Exami		4a. Facility Name (If not institution, giv			4b. City, Town, o	or Location of D	eath			of Death	
		1016 JOYCE DRIVE			CROWN	SVILLE			ANNE	ARUN	IDEL
Funeral	П	Social Security Number 6. S		rthday)	If Under 1 Year Months Days			of Birth	Day Year 7, 2006 9  4c. County of Death ANNE ARUNDE Year) 9. Birthplace Country, 1950 MARYLA  10d.  10	place (State or Foreign	
Director		214-54-0976	□ M 2ሺ F 55	Yrs.	Widiliis Days	Hours	NOV.	18,	1950	MARY	TAND
p .		Usual Residence of Decedent	10-0: 7		1.0						
aryla hov	_	10a. State 10b. County	10c. City, Tov	vn or Loc	cation						10d. Inside City Limits 1 ☐ Yes 2 No
Ba-f	cto	MARYLAND ANNE AR	UNDEL MI	LLE	RSVILLE						1 1 105 2 EN NO
ith th	Director	10e. Street and Number			10f. Zip Code			10	g. Citizen of 1	What Cou	ntry?
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lams	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. W	Vas Decedent of H Yes, specify Cub	Hispanic Origin? an, Mexican, Pi	(Specify Yes ouerto Rican, etc.	or No-			
INCLAINED SON THE MANAGE OF TH	by F	1 Never Married 2 Married	1 □ Yes 2 XXNo If Yes, Give	1	☐ Yes 2XXNo	Specify:			Specif	/	150
Z I Z I 3-UU30 d within 72 hours all giene. er than "natural", or	D D	3 Widowed 4 Divorced	Year or Dates:								
27 r	Completed	15. Decedent's Education (Specify only highest grades)		(Give I	ent's Usual Occup kind of work done OO NOT use retire	during most of	working	1	6b. Kind of Bi	nl/229nist	dustry
within	ם	Elementary/Secondary (0-12)	College (1-4or 5+)		STOMER SI	•			<b>ወ</b> ፑርጥ (	יטאיד	POT.
V 005	ő	17. Father's Name (First, Middle, Last,	1		JIOHHI D		Name (First Mi	iddle Ma			.011
Maryland d 2 should be file th and Mental Hy ?? Is marked oth traumatic event	Be	WILBUR ARTHUR					,			,	
iaryiand ZIZ Should be filed within and Mental Hygiene. Is marked other than aumatic event, ITAM	P	19a. Informant's Name/Relationship (		n Mailine	n Address /Street						Code)
C = 64 F		THOMAS NADOLSKI / 20a. Method of Disposition	20b. Place of	of Dispos	5 ELVATO	7. 17.	MILLER G. <sup>Da</sup> 31,				
	1	1 🔀 By¶al 2 ☐ Cremation 3 ☐	Removal from State	ny, crem	atory or other pla	/	G. 31, 2006				
ritan dury		4 □ Doration 5 □ Other (Specifical Security of Futural Service User		HISTOR	N MEM. P			_			
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CAPE IN CO.		23a. Part1. Enter the disease, or com	plications at caused the death. Do							2000	Approximate
		shock, or heart failure. List only	one cause on each line.		1	ng, such as can	Jiac of Tespitati	Jiy allos	ι,		Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a WAMPH	D	ncer						
/Medical Examiner			Due to (or as a consequence	of):							5 years
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ed sit	in	cause. Enter Underlying Cause (Disease or injury	Doe to (or see a so readpende	Cij							
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OK OO (OU) certificate be executed ding physician end se as the burial-transit	/Medical		, d							-	
Certification ding	Me	IF FEMALE:	23c. If yes, outcome of pregnancy						and Day		
atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal death		Ectopic pregnancy Other (specify)	у			1		Day Year
at the d by the etached	Physician	1 ☐ Yes 2 █ No 9 ☐ Unknown	9 Unknown	50	Ollier (specify)			_			
	Ph	Part II. Other significant conditions of	ontributing to death but not resulting	in the un	derlying cause giv	ven in Part I.	23e.	Did toba	cco use cont	ribute to t	he cause of death?
sign d be	d by							1 ☐ Yes	2 □ No	3 Prof	pably 4 Munknown
w require	Completed										
e lav	m						_   ;	Was an autopsy		prior to co	mpletion of cause of
icate					_		1 🗆 Y	es 2	No	Yes	
nysician: The law nysician: The law nis certificate has b I director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		! Oth		Death Check o				AUGHTER'S
Invision of vital necords, for a standing Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be	2	1 ☐ Yes 2X No 27. Manner of Death	1   Inpatient 2   EH/O	utpatient Time of	00000						y) RESIDENC
ding f h. After funer	ö	1 X Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injur Wor		280. Desc	IDO HOW	mijury occurr	90	
or Attending Physician: ther death. Director: After this certifica in by the funeral director.	icat	2 Accident Investigation 3 Suicide 6 Could not b	A			Yes 2□No	206   0001	(Ct-	at and Minnt		10-1-11
or A	Certification:	4 Homicide determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, stre	et, factory, office		City o	r Town,	State)	er or Hura	al Route Number,
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier M-f Certifying Ph	venicion. To the heat of my beautiful					46	(-) )		
Hos 24 hc Fun stely	Medical	(Check only 2 Medical Exar	ysician: To the best of my knowledg niner: On the basis of examination ar and manner stated.	e, death nd/or inv	estigation, in my o	me, date and pi opinion, death o	ace, and due to ccurred at the t	ime, dat	se(s) and ma e and place,	nner as s and due to	tated, the cause(s)
thin ;	Me	29b. Signature and different certifier	and marrier stated.		29c. Licens	se number		290	I. Date signed	1 (Month.	Dav. Year)
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		2 KILLINA	MULEVIN	(**	VC	الإي	4	F	709091	20,	2000
10		30. Name and address of person Mio	completed cause of death (Item 23a)	Type, F		112/	CO P	11	m (5)	1	71107
S. State Contract Contract		31. Date filed (Month, Day, Year)	32 Angistrar's Signature	51	71 LAC	717	(6)	المرا		4 (	- 1hU -
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 27095 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Timothy O' Neill AUĞÜST Joseph ž6, 2006 9:35 AM /Medical 4c. County of Death
Baltimore Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death Examiner Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

Min.

Months Day 29ar, 1929 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 ☐ F 77 Yrs. Maryland 220-24-2491 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Baltimore Dundalk 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2355 Searles Road 21222 USA 238 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or Items 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: White 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Bethlehem Steel 12 years .. Pages 1 and 2 should be filed v iment of Health and Mental Hygie tant: If Item 27 Ie marked other t ijury or other traumatic event, III other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William J. O'Neill Elizabeth Antmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iva O'Neill 2355 Searles Road, Dundalk, Md. 21222 wife August 29, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any Injury or once. Sacred Heart of Mary Cem. Dundalk, MD. 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral/Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of): Examiner CEREBROVASCULAR THROMBOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2X No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 💢 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1-09

Box 68760.

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Division of Vital Records, P.

State Registrar 31. Date filed (Month, Day, Year)

30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)

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JOGINDER P.

7601 OSLER DRIVE, TOWSON, MARYLAND 21204 M. D. , 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink Katrina M. Odellas State of Maryland / Department of Health and Mental Hygiene 1- For State 2006 27096 Certificate of Death Reg No. Registrar Decedent's Name (First, Middle,Last) Physician/ 2 Date of Death **Medical Examiner** 0257 hrs August 18, 2006 Katrina 0dellas 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or **Funeral** 220-86-8659 Months Days oreign reign Washington Director Hours 42 2 X F Sept. 11, 1963 M D.C Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 X Yes 2 No Maryland notified at once Anne Arundal Glen Burnie should be filed within 72 hours after death with the Maryland Director 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 115 Wells Avenue United States America Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. Yes Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify Black \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than Baltimore, MD 21215-0036 12 Health and Mental Hygiene Secretary Private 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Thomas Frank Odellas Lynn Ray Alston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn R. Odellas/Mother 3850 Enfield Chase Ct # 306 Bowie Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 x Burial 2 Cremation 3 Removal from State 8/25/2006 Donation 5 Other Specify. National Hem. FK Laurel, Maryland 21. e of Funeral Service License 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road Laurel MD 20707 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Narcotic intoxication Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and tran Physician/Medical X UNPENDED AMENDED item#23a,27,28a-f,perME,g859,9/15/06 TI attending physic or use as the burn Box 68760, IF FEMALE: 23c If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes No 25. Was case referred to medical Be 26.Place of Death (Check only one) Hospital: 1 Other Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 DOA 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 Natural Pending within 24 hours after death To the Funeral Director: Yes 2 X No Fnd 8/18/2006 Fnd 2:03 am unk 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) 115 Wells Avenue CLen Burnie, MD 3 6 X Could not be Suicide determined (Specify) House Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. August 19, 2006 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) aistrar's Signature State

ORIGINAL

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Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No 2 0 0 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician Della Pearl Parry 7:15 P M August 22,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Heritage Meridian Care Ctr. Dundalk Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 12 F 212-20-1524 Director Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural; or Items 23e or 28e-f ehow 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23e or 28e-f ehow other traumatic event, it is Nextical Executive to that be ricillist at 1 Tyes 2 No Edgewood Director Harford Maryland 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21040 1367 Harford Square Drive United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: Specify: þ 3₺ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 11 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Maggie Harpel ပ Victor Mohr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgewood, MD 21040 Mrs. Margaret Cannoles (Daughter) 1367 Harford Square Drive Department of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State injury or Meadowridge Mem. Park 8/26/2006 Dorsey, Maryland • 4 □Donation ≠ 5 □ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of uneral Service Licensee any ir Dundalk, Maryland 21222 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ron Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physiclan/Medlcal as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregns 1☐Live birth 3 Ectopic pregnancy Day in the past 12 mont 4☐Pregnant at time of death 5 Other (specify) detached 9☐ Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 2□ No 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 2 1 Yes 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and 110-A 10 32. Registrar's Signature 31 Date filed (Month, Day, Year) State

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Registrar

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**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2006 27098 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 20, 2006 10:00P M August RHODERICK EVELYN LORRAINE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 1 F Yrs. Mar 2, 1923 Director 83 214-16-1627 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County ul Hygiene. . other then "naturel", or iteme 23a or 28a-f ehow vent, the Micdical Examinar must be notified at 1 ☐ Yes 2X No Director MD Frederick Frederick 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 1421 Taney Avenue 21702 <u>USA</u> Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. unk permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or Item eny injury or other traumatic event, the Market and Once. Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🖾 No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education Public School Office unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosa C. Kinna Charles Edgar Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Memorial Hospital 400 W. Seventh St. Frederick, MD 21701 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Ser 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Ronald S. W Wade m 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent of): attending physicien and for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2 No cete has been signate, page 2 should b 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ★ No 24a. Was an certificete has 1 ☐ Yes 20 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Inpatient ER/Outpatient 3□ DOA this After this funeral of 27. Manuer of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funerel Director: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and utte of ce 29d. Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print) Name and address of person who completed ma 107 2. Registrans Signature 31. Date filed (Month, Day, Year) made State AUG 2 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2006 Month Aug **Physician** MARY 25 SIMMONS AMM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES GREATER LAUREL NURSING CTR. LAUREL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 06 · 20 · 1923 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 201 F 83 NC Director 075.16.2011 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County th and Mental Hygiene. 27 is marked other than "neturel", or items 23s or 28s-f ehow treumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No JESSUP Director MO HOWARD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8760 MARY LANE 20794 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NY PUBLIC SCHOOLS SCHOOL MONITUR 11 14 GRADE NIA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be ADA SEYMORE LEON SIMMONS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: if Item 27 I 5623 SW 51 COURT, OCALA FREDDIE MOORE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 08.29.06 ELKRIDGE, MD 4 ☐ Donation 5 ☐ Other (Specify) MEADOW RIDGE 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Fuperal Service Licensee Vanghn 5151 BALTO. NATE PIKE, BALTO. MO 23a. Part1. Entertie disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEMONIA DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any local properties cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of) burial-1 Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à MIA De menta 1 | Yes 2 | No 3 | Probably 4 Onknown ANE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 No 1 Yes Division of Vital Hospital or Attending Physician: : After this certifical funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by filled in by 4 - Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D2899X A4626 2006 ritam 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRITAM 5 5A MD 121 CHERRY Su. le 211 LANE LAUREL 31. Date filed (Month, Day, Year) 32. Registrar's Signature Sparke AUG 2 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** M 23 2006 INE? SHRIEVE HUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner RANDALLSTOWN BALTIMORE NORTH WEST HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 11 - Ob - 1933 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗷 F 238.44.8109 Yrs. NC Director Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "neturel; or Items 23s or 28s-1 show other treumstic event, the Medical Examinar must be notified at 1 No Yes 2 No Director NA BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 416 ALLENDALE STREET 21229 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after a sand Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced BLACK Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NA NURSES ASSISTANT 12 TH GRADE HEALTH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Mental Importent: if Item 27 is marked any injury or other treumatic events. DONNIE CASON IOLA SMMH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARLENE FRIERSON 927 SEDGLEY RD. CATONSHILLE, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ARBUIUS 08.28.06 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE 21. Sign ture of Fyneral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE Vaughn 5151 BAUTO, NATU PIKE, BAUTO, MD 21229 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARCINOMA disease or condition resulting in death) METASTATIC LITERINE /Medical Due to (or as a consequence of) Examiner MAINDRY Embousm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed after death. attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 □Unknown 1 ☐ Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 20 No 1 Yes 200 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 K Inpatient 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After this 28a. Dife of Injury (Month, Day Year) 27. Manner of Death Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Diractor: All completely filled in by the fu 1 ☐ Yes 2 ☐ No М investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide the Hospital 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mella m.D D41410 Hugust 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John NER P MEHTA 211 73 CENTER RANDALLSTOWN HOSPITAL MO MORTHWEST 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylan			nt of Hea te of De		Mental Hy	/giene	ZUUb	27101
i	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last)  PRG   Elizaba  4a. Facility Name (If not institution, give s  University of Mades				Town, or Loc		2. Date of Di Month	Day 2		3. Time of Death  / 0 : 44 AM
	Funeral Director		5. Social Security Number 60 Sex	7. Age (In yrs. 81			r 1 Year If l	Under 24 Hrs. ours Min.	8. Date of Bi (Month, D Feb 8	rth ay, Year)	9. Birth Con Mar	nplace (State or Foreign untry) Yland
	d within 72 hours atter death with the Maryland Jiene, rthan "natural", or items 23a or 28a-1 show the Madical Examinational Se motified at	Director	10a. State         10b. County           MD         Carroll           10e. Street and Number		y, Town or Loc kesvi]		o Code			10a. Cit	izen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	death with	Funeral Di	4470 Bartholow F	2. Was Decedent Ever in U	.S. 13. W	2	1784	nic Origin? (Sp	Decify Yes or No Rican, etc.)	Unit	ted Sta	ites
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ryland	should be filed nd Mental Hygi marked other umatic svant, II	To Be	17. Father's Name (First, Middle, Last)  Carroll Ford  19a. Informant's Name/Relationship (Typ.	D. D. Cal	100 11-77		V	irgie	May H	off		
ле, ма	fand 2 fealth a fm 27 is		Darlene Sisolak 20a. Method of Disposition	(Daughter		Ag	rippa			sbur	or Town, State, Zing, MD pocation - City or T	21784
Баціто	permit. Pages Depertment of Inportant: If ite any injury or of once.		1X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	We	stmins	ster	Cem.				stminst e and C	er, MD Crematory
00/00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after doath.  Within 24 Hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and ining by completely filled in by the funeral director, page 2 should be detached for use as the burial-transit at pure in the complete of the compl	edical Examiner	Sequentially list conditions.  Sequentially list conditions.  Lany Land Disease or injury that initiated events resulting in death)  Lany Land Disease or injury that initiated events resulting in death) Last  Lany Land Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a))).	uence of	12 W	de of dying, su	Libe:	rty Rd or respiratory a	W j	infield	Approximate Interval Between Onset and Death
.O. DOX	the death certi yy the attending ached for use a	Physician/Me	IF FEMALE: 23 b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 td No 9 ☐ Unknown	ic. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3 🔲	Ectopic p Other (sp					23d. Date of delik Month	very Day Year
cords, r	requires that the death neen signed by the atter hould be detached for u	þ	Part II. Other significant conditions cont	ributing to death but not res	ulting in the un	derlying o	cause given in	Part I.		tobacco u Yes 2	/	the cause of death?
ב	n: The law flicete hes b or, page 2 sh	e Completed	25. Was case referred to medical						1 ☐ Yes	psy ormed? 2 No	prior to co death?	opsy findings available ompletion of cause of
5	yeicia s cert directi	To B	examiner?	ospital:	ER/Outpatient	3 🗆 DX			h Check on v		6 ∐Other (Speci	(6/)
VISION OF	Attending Physician: Ir death. sctor: After this certifice by the funeral director. I		27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work? 1 🗀 Yes		28d. Describe			<i>''</i>
2	o ths Hospital or Att vithin 24 hours after de to the Funeral Direct completely filled in by t	Il Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specifican: To the best of my kno	·)				City or To	wn, State	)	al Route Number.
	# Hos 24 hc Fun letely	edical	(Check only 2 Medical Examinone)	er: On the basis of examina and manner stated.	tion and/or inve	estigation	, in my opinior	ate and place, n, death occur	red at the time,	date and	and manner as s place, and due t	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29	c. License nun	nber		29d. Dat	e signed (Month,	Day, Year)
	20		Melisse Bok 30. Name and a dress of person who com	npleted cause of death (Item		Print)	3-115			S	2/26/06	
Ē,	Sta Registr		31. Date filed (Month Off, Bas 200	7774 May Sar 6 32 Registrar's Signa	Cirde ,	Ellic	off Gry	MD &	1043			

DHMH 17 Rev 1/2001

kevin Snarpe 06-06247 UNK UNK

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day August 21, 2006 Medical Examiner 0523 hrs Harri 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death c. County of Death 3700 Beehler Avenue Baltimore V 5. Social Security Number 6. Sex If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Hours Min Director Months Days 216-96-0172 M 2 Country) Usual Residence of Decedent any 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be notified at once, Yes 2 No 4 a xaltimore Cochearn hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country جا فا فا 2120 Fores Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married 1 Yes If Yes, Give Year Divorced 3 Widowed 1 Yes 2 No specify: Specify Black ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Kind of Business/Industry Completed during most of working life DO NOT use retired) t Pages I and 2 should be filed within 72 htmnt of Health and Mental Hygene rant: If item 27 is marked other than "n or other traumatic event, the Medical F. Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be 024150N 19a. Informant's Name/Relationship (Type, Print ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grandmothe Road tores + 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State crematory or other place) mportant: 29/06 wadbook Woodlawn Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of Facility NPMERO FUNZICI HOME ha Baltimole Md 21215 heisterstown the direase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician ailure. In only one cause on each line Between Onset and /Medical Death mmediate Cause (Final disease a Multiple Gunshot Wounds Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury trial initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and rans Physician/Medical UNPENDED ending physician use as the burial AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Fetal death Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, this certificate has been said director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? ✓ Yes 2 1 🗸 25. Was case referred to medical 26. Place of Death (Check only one) of Vital æ examiner? Hospital: Other<sub>4</sub> Inpatient ER/Outpatient 3 DOA Nursina Home 5 Residence 6 🗸 Other: Scene 1 V Yes 28a. Date of Injury FOUND: After Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot Natural FOUND: Division Director: d in by the f Pending Yes 2 V No Aug 21, 2006 0520 hrs Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3700 Beehler Avenue, Baltimore, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide determined (Specify) Local Street 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signatule and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E August 21, 2006 30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Carol Allan, MD 111 Penn Street, Baltimore, MD 21201 31 Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 8 2006 Registrar

OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month 1220 22 2006 106 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 1+OSPITAL BALTIMORE BALTIMORE ST AGNES 7. Age (In yrs. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign last birthday) 6. Sex 5. Social Security Number Days Hours 1 □ M 2 KF Months 214-70-9903 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Co 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black White etc. ☐Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) coddary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City of John, State, Zip Code 13309 SON 20b. Place of Disposition (Name of cametery, crematory or other place)

Date

C. Location - City or Town, State Bakers Field, Car 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8-28-2006 Baltimore, MD Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc 21. Signature of Funeral Service Licensee 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer Lung Unknown Due to (or as a consequence of): Sequentially list conditions, if any, leading to lumine flate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performs 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

ir than "natural", or iteme 23a or 28a-f ehovithe McGcal Examiner must be notified at

other

it of Health and Mental Hyg If Item 27 is marked other or other traumatic event,

Department o Important: If eny injury or one one

filed within 72 hours after

Pages 1 and 2 should be

Maryland 21215-0036

Baltimore,

Records, P.O. Box 68760

Division of Vital

the

Funeral Director

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Completed

Be

The law requires that the death certificate be executed physicien at sthe burial-t ettending p ed by the detached cate has been signated to page 2 should to r: After this certifica e funeral director, p Hospital or Attending Physician: death. after death Director: / filled in by within 24 hours an

Completed by Physician/Medical Be Certification: To

IF FEMALE

27. Manner of Death t WNatural

2 Accident

3 🗌 Suicide

4 | Homicide

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

AUG

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

CHEEMA M.D 29b. Signature and title of certifier

29c. License number D0063025 29d. Date signed (Month, Day, Year)

2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A AM/R CITE MA OWINGS 5124 STONE SHOP MILLS CIRCLE

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 2 8 2006

5 Pending investigation

6 Could not be



			For State Registrar	State of N	-	epartment of F Certificate of		nd Mental Hy	giene Reg. No. 20	06	27104
	D		1. Decedent's Name (First, Middle, La	ist)				2. Date of De	ath		3. Time of Death
	Physici: /Medic		Helen			dden		Augus			10:40 PM
	Examin		4a. Facility Name (If not institution, given 363 Point to P	oint Roa	ıd	4b. City, Town, o Belair				ford	
	Funeral Director		233-26-9600	Gex 7. / 1 □ M <b>3/</b> [XF	Age (In yrs. last birth 84 Yı	Monthe Dave	Hours	Min. 8. Date of Bir (Month, Date of Cotober	12, 1921	9. Birthp Coun West	lace (State or Foreign lity) Virginia
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				1	Od. Inside City Limits
	Mary -1 sho	ξ	Maryland Harfo	rd	Belai	.r					1 ☐ Yes 2 🛣 No
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	itry?
	238 c	aiD	363 Point-to-Poin	t Road		210	15		USA		
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "netural", or items 23a or 28a-f show event. The Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates	XNo	13. Was Decedent of F If Yes, specify Cub 1 ☐ Yes 2 X No	lispanic Orig an, Mexican, Specify:	gin? (Specify Yes or No , Puerto Rican, etc.)		ce - Americ ck, White, y: Whi	etc.
0-0	2 hou		15. Decedent's E		16a. C	ecedent's Usual Occup Sive kind of work done	oation	of working	16b. Kind of B	usiness/Ind	dustry
21	within 7 ene. then "r	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4c	or 5+)	fe. DO NOT use retire	d)	or working	Baltimo	re Ci	ty Police
21	e filed within Il Hygiene. other then "	Sol	12 years		Sı	pervisor	40.14.1	d- 11 (5' 15'-d')		partn	ent
Maryland 21215-0036	ntal H	Be	17. Father's Name <i>(First, Middle, Las)</i> Vaclav Honce	")			1	r's Name <i>(First, Middl</i> e y <b>Rabik</b>	, Maiden Sumar	ne)	
7	s 1 and 2 should be f Heelth and Mental item 27 ie marked o other treumatic eve	유	19a. Informant's Name/Relationship	(Tyne Print)	19b J	Aailing Address (Street		r or Rural Route Numb	er City or Town	State Zin	Codel
Ma	nd 2 s lith an 27 ie : r treu	ij	Sheila C. Durst	Daughter		-		Abingdon,			009
re,	s 1 and 3 Heelth Item 27 other tr	13	20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other pla		August 28,	20c. Location		own, State
9	Page ent o nt: if		1 X Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci		oak La	wn Cemeter	Y	2006	Dundal	k,MD.	
Baltimore,	permit. Pages I Depertment of H Important: If Ite any injury or ot once.		21. Signature of Funeral Service Lice	nsee (M)	neller	Connelly F 7110 Solle	unera ers Po	Home Of I	Dundalk, Dundalk,	P.A. MD. 2	.1222
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caus	ed the death to no						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		cardial						Onset and Death
	/Medical Examiner		resulting in death)		as a consequence of	1		sease			
	Examiner		Sequentially list conditions,	b. Coro	nary (	untery	dis	sease			
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequence of	- )					
•	xecut and al-trar	xau	that initiated events resulting in death) Last	c. Due to (er	as a consequence of	:					
8760,	ate be executed hysicien and the burial-transit	dical E		d							
687	ificate g phy: as the	edic		d							
Box	e death certific the attending p ned for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	у			ite of delive onth	ory Day Year
P.0	that the de led by the a detached		Part II. Other significant conditions	contributing to death	but not resulting in t	he underlying cause gr	ven in Part I.	23e. Did	obacco use con	tribute to th	ne cause of death?
Division of Vital Records,	9 PB	ed by	Polycyt	hemia	Vera			1 🗆	Yes 2□No	3 🗆 Prob	ably 4 Unknown
CO	≥ 11 0	Completed	' '					24a. Was		Were auto	psy findings available
Re	The lav ete has page 2	E						—— auto perfe 1 ☐ Yes	ormed?	death?	impletion of cause of 2□ No
ital	stan: artifice ctor, g	Bec	25. Was case referred to medical examiner?		-		26. Place	of Death Check only	7-		
× ×	Physician: this certific ral director,	မ	1 ☐ Yes 2 No	Hospital: 1 Inpa		atient 3 DOA			dence 6 Oth		y)
Ē	ing P	Ë	27. Manner of Death 1 XNatural 5 ☐ Pending		njury 28b. Tir Day Year) Inj	ury Wo			how injury occur	rred	
isio	Attending r death. ector: Afte by the fune	icat	2 Accident investigation 3 Suicide 6 Could not l	De 28a Ptace of	Injune - At home fare		]Yes 2□h		Street and Num	her or Rura	I Route Number.
Σ	for A effer Direct	Certification:	4 Homicide determined	building,	etc. (Specify)	n, street, factory, office			wn, State)	Jei di Mara	i riodie ramber,
_	To the Hospital or Attending P within 24 hours effer death.  **To the Funerel Director: After to completely filled in by the funeral completely filled in the funeral compl	edical C	29a. Certifier Certifying P (Check only 2 Medical Exa	hysician: To the be miner: On the basis and manner	st of my knowledge, s of examination and stated.	death occurred at the to or investigation, in my	me, date and opinion, deat	d place, and due to the th occurred at the time,	cause(s) and m date and place,	anner as s	tated. o the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of officer			29c. Licen	se number	_	29d. Date signe	ed (Month,	Day, Year)
	3		> h//	( us		DS.	514	3	8/2	4/0	06
ı	D		30. Name and address of person who	completed cause	f death (Item 23a) (T	ype, Print)	01 4	700 Anl	1	٠, ١	21015
l			KARL SPECT	or mi	2014	10119ate	140 H	wo bel	Pris 1 Po	، دیر	-1013
	Sta Registi		29b. Signature and title of priffier  30. Name and address of person who KAM SPECT  31. Date filed (Month, Day, Year)	OS Regi	Strar's Signature	JASA SA					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2006 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 22, 2006 Year Physician 9:30a Emma Marie Schneider /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Brooklyn Park 5800 Redmond Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 5, 1924 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2**X** F Virginia Yrs. 81 Director 223-26-5424 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "natural", or items 23a or 28a-f show the Medical Exercines must be notified at 1 Yes 2 No Brooklyn Park Maryland | Anne Arundel Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? IISA 21225 5800 Redmond Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2% No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) Phone Company Telephone Operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth ery liqury or other traumatic event ODE. Be Mary Bledsoe ဥ Grover Bledsoe 9a. Informant's Name/Relationship (Type, Print)

Charles M. Donaldson (Per. Rep.) 3727 Greenvale Rd., Baltimore, MD 21229 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Wother (Specify) Entombment Loudon Park Cemetery 8/25/06 Baltimore, Maryland Loudon Park Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service License 3620 Wilkens Ave., Baltimore, MD 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Obstructive Pulmonary Tricale Immediate Cause (Final Severe Cheonic 10 years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 PYes 2 □ No 3 Probably 4 □Unknown Completed peed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 🗌 No : After this certifical funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No M investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D0056468 22, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 1120 N ROLLING ROAD, CATONSVILLE, MD 21228 KHIN-RUPA MAUNG, MD 31. Date filed (Month, Day, Year) 8 2006 32. Registrar's Signature State Registrar

06-06411

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Lartoria Thorton 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month August 27, 2006 0438 hrs / HORNION **Medical Examiner** LATORIA TAMERA 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death St. Agnes Hospital Baltimore NA 5 Social Security Number If Under 1 Year If Under 24Hrs. B. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Foreian Months Days Hours Director Country) 29 214.96.833 1 M 2 X F 05.31.1977 MD Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No NA BALTIMORE 28a-f shov MD Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene ant. I filem 27 is marked other than "natural", or items 23a or 28a-f 5th or other traumatic event, the Medical Examiner must be notified at once 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? AVENUE APT. D 21229 USA SAYER ā 4118 Was Decedent Ever in U.S. Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14 Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married Married 2 0 No Yes Widowed Divorced f Yes, Give Year Yes 2 No specify. Specify: BLACK þ 16a Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 121H GRADE SPECIALIST UNIV. OF MD 1B.Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last Be THORNTON ELENIA WILSON ımatic event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ 19a Informant's Name/Relationship (Type, Print MOTHER 1HORNTON 4100 DARTFORD AVE BALTO. MD 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition crematory or other place) 1 K Burial 2 Cremation 3 Removal from State Department of Important: I 09.01.06 MT. XION BALTIMORE Donation 5 Other Specify ignature of Funeral Service Licensee Name and Address of Facilit YAUGHN C. 5151 BALTO. GREENE FUNERAL SERVICE NATT. PIKE BATO. MO Part ICEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical a Smoke Inhalation Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED physician item#1,perME,g859,9/25/06TI Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? for use Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown the signed by the be detached 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of this certificate has performed' death? Yes 2 V No fo the Hospital or Attending Physician: 26.Place of Death (Check only one) 25 Was case referred to medical æ Other<sub>4</sub> Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 DDA Nursing Home 5 Residence 6 Other 1 V Yes After 1 2Ba. Date of Injury 2Bb. Time of Injury 28c. Injury at Work 2Bd Describe how injury occurred 27. Manner of Death Certification: Victim of housefire Aug 27, 2006 Natural 0415 hrs Yes 2 V No after death the Pendina Director: 2 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be or Town, State)
4718 Sayer Ave. Apt. D, Baltimore, Md. Suicide within 24 hours at To the Funeral L determined (Specify) Multi-Family Apt. Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d Date signed (Month, Day, Year) August 28, 2006 O.C.M.E. who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. 31. Date filed (Month, Day, Year) State 2006 Registrar

State of Maryland / Department of Health and Mental Hygien 2006 1 - For State Ragistra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Qust 23 2006 10:56 A M homas - Linder psita /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Ba Himore Spring Avenue Kosedale If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 M 2 1 € Days Hours 213-72-7471 Director 1962 Germany Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c, City, Town or Location 10b. County itam 27 is markad other than "natural", or itams 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No by Funeral Director Rose da le Itimore 10e, Street and Number 10g. Citizen of What Country? daath with 6106 Shad avenue **グ1237** USA 12. Was Decement Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after deal Depurtment of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural" ~ " any njury or other traumatic even." 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes MNo Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Supervisor <u>Horticulture</u> 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Karli Salme Maria Lang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Krystal Thomas (daughter) 3500 Northway Drive Parkville, Maryland21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview CrematoryAug24,2006 Baltinore, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility 21. Signature of Funeral Service Licenses 1201 Dundalk ave Fineral Home PA. Baltimore, Ald 21722 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician STARVATION /Medical Due to (or as a consequence of): Examiner CHRUNIC BOWEL OBSTRUCTION Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a nonsequence of) Physician/Medical Examiner burial-transit The law requires that the death certificate be executed OUARIAN attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, usa as tha IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo Month in the past 12 months? 1 ☐ Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) ad by tha a 9 Unknown 9 Unknow signad Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pa 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 2**/2** No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 sidence 6 □Other (Specify) 2 1 ☐ Yes 2 X No 4 Nursing Home this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a, Date of Injury Certification: 1 Natural 2 Accident 5 Pending investigation after daath. 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide To the Hospital 24 hours 29a. Certifier 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2 To tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 116801 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2200 9103 20 blare 31. Date filed (Month, Day, Year) State Registra

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 7:50 PM AUGUST 22, 2006 Virginia Wheeler

4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death 4b. City. Town, or Location of Death Examiner ST BALTIMORE HOSPITAL AGNES If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 91 Yrs 2110-01-2540 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No MI Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Itams 23a or 100 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: þ 3 X Widowed 4 ☐ Divorced Black "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) than College, (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surmame) Seanstress permit. Pages 1 and 2 should be filed w Deperment of Heelth and Mental Hygier Important: If Item 27 is marked other th any Injury or other traumatic avant, the once. Grade NA manufacturing 17. Father's Name (First, Middle, Last) UNK Metilda Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4239 Borne Rd, Baltimore, MD 21216 Chester Massenburg (nephew) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Garrison 4 ☐ Donation 5 ☐ Other (Specify) Forest 9/1/2006 Cwings Mills MI 21. Signature of Funeral Service Licensee 22. Name and Address of Facility weral Svc Vauchn 5151 Balto Watt P.Ke Baltimore, MD 21229 Greene Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) MYOCARBIAL AUTE INFARCTION-3 WEFKY. **Physician** /Medical Due to (or as a consequence of): WEEKS ASPIRATION Examiner PREUMONJA. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner RENAL FAILURE 2 WEEKS. ACUTE or Attanding Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records, SEPSIS 1 Yes 2 No 3 Probably 4 Dunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 212 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ VV 1 Depatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Matural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After Division 5 Pending To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P-18613. MUHAMMAD SAIM, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUHAMMAD SATM, M.D. 900 S. CATON AVE. BALTIMIRE, MD - 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

DHMH 17 Rev 1/2001

VIRCINIA

~ HEELER

State of Maryland / Department of Health and Mental Hygiene 10 6

			For State Ragistrar	Cei	rtificate of Death	7	Rag. No.	2/109
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  EVPLYN  S	PATER		2. Date of Dea Month	Day Year	3. Time of Death  1\25AM
	Examir			SAPPA14C	4b. City, Town, or Location	-D	4c. County of Dea	ARUNDOL
	Funeral Director		5. Social Security Number  215-20-5742  Usual Residence of Decedent  6. Sex  1 □ M 2 ☒ F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year If Under Months Days Hours	Min. 8. Date of Bird (Month, Da JAN 9		thplace (State or Foreign ountry) XYLAND
	Maryland -f show	tor	10a. State 10b. County MARYLAND ANNE ARUNDEL	10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 XNo
	th with the 23s or 28s	ai Director	10e. Street and Number 8049 VETERANS HIGHWAY,	LOT 60	10f. Zip Code 21108		10g. Citizen of What Co	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic event, the Madical Franchist roual be notified at ODGE.	by Funerai	Armed F	2.2.No	Was Decedent of Hispanic Of If Yes, specify Cuban, Mexica 1 ☐ Yes 2 ☒ No Specify		Specify:	
21215-0036	within 72 ho ane. than "natur is Madical	Completed	15. Decedent's Education (Specify only highest grade completed  Elementary/Secondary (0-12)  College	(Give life.	dent's Usual Occupation kind of work done during mo DO NOT use retired) WRAPPER	st of working	16b. Kind of Business GROCERY	/Industry
	il Hygie other	Be Co	17. Father's Name (First, Middle, Last)	111111		ner's Name (First, Middle,		
ylar	should be ind Mental marked o	To B	(UNKNOWN)		(t	JNKNOWN)		
Maryland	2 sho and is ma		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Numb			
	1 and Health Iem 27	13	CINDY A. HACKLEY / NIEC  20a. Method of Disposition	20b. Place of Dispo	2 HARWICK CT.,	Date	20c. Location - City or	
Baltimore,	it. Pages rtment of rtent: If it njury or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from 4 ☐ Dollation 5 ☐ Other (Specify)  21. Signature of Funaral Service Depases	METRO CRI	EMATORY, INC,		CATONSVILLI	E, MARYLAND
Ba	permit. Departifmport. any inj		) All of the	42	2. Name and Address of Facil IRKLEY-RUDDICH 21 CRAIN HWY.	, S.E., GLEN	BURNIE, MI	
*	Physician /Medical Examiner			caused ine death. Do not entreach line.  DVANCE (or as a consequence of):			rest,	Approximate Interval Between Onset and Death
68760,	lificate be executed lg physician and as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(or as a consequence of):  (or as a consequence of):				
.O. Box 68	es that the death certifica igned by the attending ph be detached for use as tt	Physician/Med	in the past 12 months?	nant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	liv <b>er</b> y Day Year
<u> </u>	w requires that been signed b should be deta	Ď	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part		obacco use contribute to res 2 ØNo 3 □ P	the cause of death?
Vital Records,	The la ate has page 2	Completed				24a. Was autor perfo 1 \( \text{Yes}	prior to death?	utopsy findings available completion of cause of
Š	Physician: Th this certificate ral director, pag	Be	25. Was case referry to medical examiner?  Hospital:	-0500	Othor	Death (Check only o	7.52	
on of	Jing Aftar fune	ition: To	27. Manner of Death 28a. Date	Inpatient 2 ER/Outpatier of Injury oth, Day Year)  28b. Time o Injury	IL 3 DOA 40 N		dence 6 U0ther (Spe	city)
Division	or the	Certification:	3 Suicide 6 Could not be 28e. Place	e of Injury - At home, farm, str ling, etc. (Specify)	reet, factory, office	28f. Location (S City or Tox	Street and Number or R vn, State)	ural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edicai		e best of my knowledge, deatl basis of examination and/or in oner stated.	vestigation, in my opinion, de	ath occurred at the time,	date and place, and due	a to the cause(s)
)	To See Help	Σ	29b. Signature and title of certifier	for MC	29c. License number 0463	60.	August :	77 7001
1.	)		30. Name and address of person who completed can	ise of death (Item 23a) (Type,	Print)	GHNAY 1	MILLASVI	We MD
10	Sta Regist		31. Date filed (Month, Day, Year) 32	egistrar's Signature	roll			

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 8:20 2006 August O. Abicht, Jr. Aug. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** 3461 Nanmark Ct. Ellicott City Howard If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. last birthday) 5. Sociel Security Number **Funeral** 1**⊠**M 2□F 81 Maryland Director 220 12 7964 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. Sfate 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ➡No Directo Ellicott City Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21042 USA Items 23a 3461 Narmark Ct. by Funeral Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Never Married 2X Married ö If Yes, Give Year or Dates: 1943-45 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 Widowed 4 Divorced "natural", Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. important: if Item 27 is marked other than \*\* any injury or other traumatic event, the Med once. than, Elementary/Secondary (0-12) College (1-4or 5+) 2 Superintendent of Cost Railroad 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ethel Robey August Abicht 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ellicott City, MD 21042 Loisann Abicht/wife 3461 Nanmark Ct. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Sfete 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Crestlawn Mem. Gards.8/16/2006 Marriottsville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01442 21. Signature of Funeral Service Licenses 4112 Old Columbia Pike Ellicott City, MD Verusi Kudal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approxi*m*ate Interval Between Onset and Death Immediate Cause (Final disease or condition CONGESTIVE **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner DRONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Medical Certification; To Be Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 2 Fetal death Month Day in the past 12 months? detached for 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 1 ☐ Yes 2 ☐ No 3₽Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 XNo 1 Yes 2√ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 3□ DOA 2 ER/Outpatient 28a. Dafe of Injury (Month, Day Yeer) 28c. Injury at Work? in by the funeral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Injury 1 Nafural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident after death 6 Could not be determined 28e. Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours a To the Funeral L pellii 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 46300 MD 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) Dr. McCarthy 10700 Charter Drive Suite 200 Columbia, MD 21044 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 1 5 2006

		1	For State Registrar	State of N	Marylan				ealth a Death			Reg. No	200		1 1 1
	Physicia		Decedent's Name (First, Middle,     Juan B.	*	I.C.O.						2. Date of De Month Aug.	eath 9 - 20	0.6 Ye	ar	e of Death
	/Medic	al -	4a. Facility Name (If not institution,				4b. City,	Town, or	Location of	of Death			County of D		
	Examin	er	Casey House					ckvi				M	_	omery	
	uneral Director		224-57-9458	i. Sex 7 1 <b>∑</b> IM 2□ F	Age (In yrs. i	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di May1	ay, Year)		Birthplace (Sta Country) Colomb	
laryland	ehow		Usual Residence of Decedent           10a, State         10b, County           MD         Monto	gomery		y, Town or Lo	_								e City Limits
death with the Maryland	a or 28e-f	Direct	10e. Street and Number 17416 Beauvoi	r Blvd.			10f. Zig	Code 20	)855			•	zen of Wha	t Country?	
USO urs after death	Department of Health and Mental Hygiane. Importants: if item 27 is marked other then "natural; or items 23s or 28e-f show importants: if item 27 is marked other then "natural; or items 23s or 28e-f show ance, or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force	s? XNo		Was Dece If Yes, spe 1 XXYes				ocify Yes or N Rican, etc.)		Black, V	American India Vhite, etc. White	n,
d Z I Z I 3-UU30 filed within 72 hours after	ne. hen "natur e Wedical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4d	or 5+)		dent's Usu kind of wo DO NOT u	ork done d se retired	<i>during</i> mos )	st of worki	ng		coun	ess/Industry	
yland A	ked other ic event, II	To Be Co	12 17. Father's Name (First, Middle, L. Jesus Arango	1							(First, Middle ad Za	e, Maiden	Sumame)	<u> </u>	
Mary d 2 shou	and M is mar aumat	-	19a. Informant's Name/Relationshi								I Route Numi				20855
Baltimore, IV	of Health If Item 27 or other tr		Analegia Ara  20a. Method of Disposition  1 Burial 2 Stremation	ango/Wife	20b. P	lace of Dispo emetery, crei	sition (Na	me of other plac	e)		ate	20c. Lo	cation - City	y or Town, Sta	9
III Pag	ntment ortant:	,	4 Donation 5 Other (Sp. 21. Signatur of Juneral Service)	9 <b>/13</b> )	(	Chesa								lle,Mo	
a g	impo gua gua gua		23a. Part1. Enter the disease, or o	inth	sed the deat	9	241	Colu	umbia	a Bl	vd.Si	lver		Approx	120910
be executed	ysician and sician and sician and sician and sician and sician sician and sic	Ilcal Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a. End  Due to (or  b. Sick  Due to (or  Coro	stage as a conseq s sin	us sy: wence on. arte:	ndro	me		e				Onset	Death
.O. BOX 68/ the death certificata	by the attanding ph tached for use as th	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 ⊡Feta tattime of d	Il death 3	⊒Ectopic p ⊒ Other (s						23d. Date o Month	-	Year
J \ \f	pe eq		Part II. Dther significent condition	The second second		sulting in the u	ınderlying	cause giv	en in Part	Ι.		tobacco		te to the cause	
Vital Records, P	cate has been si page 2 should l	Completed	Dementia, No	OS							24a. Wa aut per 1 □ Yes	opsy formed?	prio dea	re autopsy find r to completion th? Yes 2 \(\sum \) No	of cause of
/Ita	is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				OA Oth			h (Check only				
Vision of Vita Attending Physician:	n. After this funeral di	tlon; To	1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investig	28a. Date of (Month,		ER/Outpatie 28b. Time o Injury		28c. Injur Wor	4014		me 5 ☐ Re 28d. Describe			(Specify)hos	spice
Division of	s after death of Director: od in by the	Certification;	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of	f Injury - At h , etc. <i>(Speci</i>	ome, farm, st	reet, facto	ry, office				(Street ar own, State		or Rural Route	Number,
Div To the Hospitel or	within 24 hours after or To the Funeref Directompletely filled in by	Medical (		Physician: To the because in the bas and manne	is of examina										use(s)
To th	within 2 To the 8 complet	Me	29b. Signature and title of certifier				2:		e number				-	Month, Day, Ye	
			Kyrihia m					110	058	032	7	any	just!	9,200	0
1			30. Name and address of person of Cyrthia M.W.	illiams,	D.O.	600	1 Mu		stre	Mil	l Rd.	Roc]	kvill	e,Md 2	20855
	St Regist	ate trar	31. Date filed (Month, Day, Year)	1 2006	Select .	H. M	park	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2006 5:15 AM <sup>™</sup> **Alexander** 10, Ε. Aug. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda Montgomery 6021 Ridge Drive If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 15,1910 Birthplace (State or Foreign Country) **Funeral** Days Min Months Hours 1 ☐ M 2 🗙 F Yrs. 96 Director Virginia 578-34-3893 Usuel Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show the Medical Executive must be notified at 1 Yes 2 No Directo Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a U.S.A. Funerai 6021 Ridge Drive 20816 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black White etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏋 No Specify: δ Specify: White 3 Nidowed 4 □ Divorced naturai Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na eny injury or other traumatic event, the Moule once. Elementary/Secondary (0-12) College (1-4or 5+) Dental Sales Specialist S.S. White Dental 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ္ပ John Isaac Revnolds Evelyn Josephine Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6021 Ridge Drive Bethesda, Maryland Marjorie Imlay/Niece 20b. Place of Disposition (Name of cometery, crematory or other place)
Metropolitan 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2006 4 □ Donation 5 □ Other (Specify) Alex., Virginia Crematory 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 2222 Wisconsin Ave., N.W. Wash., DC 20007 Approximate Interval Between Onset and Death 23a. Pant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cerebrovascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any lacking to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 2 X No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 | Inpatient 2 | EP/Outpatient 3 | DOA 1X Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ulm ( 7 rue man 17208 DC Aug. 10, 2006

Registrar
DHMH 17 Rev 1/2001

State

5

4910 Mass. Ave. NW #212 Washington, D.C. 20016

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Helene C. Freeman, M.D.

31. Date filed (Month, Day, Year)
AUG 1 1 2006

State of Maryland / Department of Health and Mental Hygiene 2 006 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Carole Anderson Lee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 0287217 Salislaun pospile of the DVNICK If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day. **Funeral** Days Hours 1 ☐ M 2 🔀 F Yrs. 4/17/1936 220-32-1734 Maryland Director Usual Residence of Decedent the Maryland 10b. County 10d. Inside City Limits 10a State 10c. City. Town or Location 23a or 28a-f ehow the Medical Examiner must be notified at 1X Yes 2 No Salisbury Maryland Wicomico Direct 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 1204 Riverside Drive 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian or Items 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Teller Banking other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any liqury or other traumatic event once. 17. Father's Name (First, Middle, Last) William Dryden Sr. Jane Weaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1204 Riverside Dr., Salisbury, MD 21801 Levin Anderson Jr./husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rock Creek Cemetery 8/15/06 Chance, MD 4 □ Donation 5 □ Other (Specify) 21 Signature of Funer I Service Licens 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 P.11. Enter the disease, or complications the cau-lock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa Olivasa or injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Iding physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 pronths?
1 □ Yes 2 No 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 2 No 3 Probably 4 Unknown 1 🗆 Yes 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificele 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After ospiter ...
4 hours after dea...
-rsl Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a: To the Funeral D 🗹 Certifying Physician: To the best of my knowledge, death becomed at the time, date and place, and due to the cauca(s) and makiner as stated 29a. Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title Name and address of person who completed cause of death (Item 23a) (Type, Print) Corstal 6/20 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 4 2006 Registrar

ORIGINAL

			For State Registrar	State	of Maryl		artment of F ertificate of		nd Mental Hy	Reg. No.	06 27114
	Physicia	an	1. Decedent's Name (First, Middle Gladys Virgini						2. Date of De AMonth AUGUST	Day	Year 2006 2 24 AM
}	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	or Location of		4c. County	of Death
			Washington Co	unty Hos	pital		Hagers			Wash	nington
	Funeral Director		5. Social Security Number 212-24-3383	6. Sex 1 ☐ M 21X F		78 Yrs.	Months Days	If Under 2 Hours	Min. 8. Date of Bi (Month, Di Oct. 4	ay, Year)	9. Birthplace (State or Foreign Country) Maryland
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town or I	ocation				10d. Inside City Limits
	Aaryli f eho	ō		hington		Hagers	Orm				1 ☐ Yes 2 🕱 No
	28a-	Tec.	10e. Street and Number	HIHECOH		nagers	10f. Zip Code			10g. Citizen of \	What Country?
	3a or	٥	11019 Lincol	n Awaniia			21740			USA	
	death ms 2	era	11. Marital Status	12. Was D	ecedent Ever i	n U.S. 13			in? (Specify Yes or No Puerto Rican, etc.)		e - American Indian,
920	72 hours after death with the Maryland 'natural', or items 23a or 28a-f ehow Jign Examir ar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	ried 1 TY6	Forces? es 2 🖾 No Give er Dates:		1 ☐ Yes 2X No		Puerto Alcan, etc.)		ck, White, etc. v: White
Maryland 21215-0036	filed within 72 hours after death with the Marylan I Hygiene. other then "natural", or items 23e or 28e-f ehow vent, the Moulcal Exercities must be notified at	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)		ed)	16a. Dec (Giv life.	edent's Usual Occup e kind of work done DO NOT use retire	oation during most d)	of working	16b. Kind of B	usiness/Industry
212	d with	mo.	4	001109	0 (1 101 01)	De	livery			Phar	macy
P	s 1 and 2 should be filed f Health and Mental Hygi Item 27 le marked other other treumatic event, I	Be	17. Father's Name (First, Middle,						r's Name (First, Middle		10)
<u>Ja</u>	should be nd Mental marked matic ev	2	Victor Daniel	Mills					lla Wolfe N		
ar.	2 shd and le m		19a, Informant's Name/Relation						r or Rural Route Numb		
	1 and 2 Health tem 27		Guy L. Boward	III/Son					Road, Hage		
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal fro	om State	cemetery, cr	osition (Name of ematory or other pla	ce)	Date	20c. Location -	City or Town, State
Ë	permit. Pages Department of I Importent: If Its eny Injury or of	-	4 Donation 5 Other (	Specify)			en Cemete		8/22/2006		town, Maryland
Sall	Departitude Depart		21. Signature of Funeral Service	Licensee					Rest Have		
=	40 E • Q		J. Nuc	Suppl							Approximate
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications the t only one cause of	at caused the con each line.	leath. Do not e	nter the mode of dyl	ng, such as o	cardiac or respiratory	arrest,	Interval Between Opset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Was	sive	guo	in	tavelle	09	16hores
	Examiner			Due	to (or as a con	isequence of):	(ke	neus	thron	lose.	s 16hours
	₽ ≃	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	to (or as a con	sequence of):					
	te be executed ysicien end ne burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	A- /						
760,	oe ex		Todaking in dodain, basi	I Due	to (or as a con	sequence or):					
687	# % e	dical		d							
.O. Box 6	ne death certifical the ettending phy thed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	1 ☐ Liv 4 ☐ Pr	outcome of pre ve birth 2 1 s egnant at time nknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у			ate of delivery onth Day Year
<u>α</u>	that the de led by the e detached		Part It. Other significant condit	ions contributing t	o death but not	resutting in the	undertving cause gr	ven in Part I.	23e. Did	tobacco use con	tribute to the cause of death?
Records,	sign d be	βp								Yes 2 No	3 Probably 4 Unknown
Ö	w requ	Completed							24a. Wa	246	Were autopsy findings available
Rec	The law	E D							auto	opsy ormed?	prior to completion of cause of death?
a	Iclan: The certificete ector, pa	e Co	25. Was case referred to medical						1 Yes		1 ☐ Yes 2 ☐ No
Vital		00	examiner?	Hospital:	(Theoretical	2 ER/Outpati	ent 3 DOA Ot	hor	of Death (Check only rsing Home 5 Res		or (Corolla)
of		. To	27. Manner of Dy th	28a.	Inpatient ate of Injury fonth, Day Yea	_	of 28c. Inju			how injury occur	
Division	or Attending Fifter death. Director: After in by the funer.	itio	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (A igation	Month, Day Yea	r) Injury		irk? ]Yes 2.∐1	No		
/isi	Attendi	ifica	3 Suicide 6 Could	minor 200. FI	ace of Injury	At home, farm,	street, factory, office				ber or Rural Route Number,
ă	afte afte	Certification:	4 Homicide	- Di	uilding, etc. (Sp	өсіту)			City or 16	own, State)	
	To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completely filled in by the	edical (	29a. Certifier Certifyi (Check only one) Certifyi	Examiner: On th	the best of my le basis of exam nanner stated.	knowledge, de nination and/or	ath occurred at the trinvestigation, in my	me, date and opinion, deat	d place, and due to the th occurred at the time	cause(s) and m , date and place,	anner as stated. and due to the cause(s)
<b>\</b>	To the within 2 To the comple	Me	29b. Signature and title of certific		2 C	7) 0	29c. Licen	se number	75	29d. Date signe	ed (Month, Pay, Year)
,	0		0/9	150V	1	ent	Total U	309	13	Ope	TIVE
	18		30. Name and Advace p or STEPHEN V	who completed o	ause of death	(Item 23a) (Typ	18 M	115	+ 410.	o vs to	Jn, M1) 2174 1
	Sta	to.	31. Date filed (Month, Day, Year	) . 3	2. Registrar's S	ignature	0 1.0		1 1 1 1	C-3100	110000
	Regist		1	8 2006	1	1	0-		O		
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						ORIG	INAL				

			1 - For State Registrar	State of Marylan		artment of I		nd Mental H	ygiene Reg. No	711116	27115
200	Physici /Media			che Dixon Bou	lden_			2. Date of Month	45t Da	19,2006	3. Time of Death 08:58 A M
	Examir	er	4a. Facility Name (If not institution, give s Calvert Manor Heal			4b. City, Town, o		Death /	4c.	County of Death	
	Funeral	.'	5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24		Birth Day, Year)	9 Birthr	lace (State or Foreign
	Director		Usual Residence of Decedent	M 2 XF 80	Yrs.		Hours	Min. (Month, March	2, 192	6 Mary	land
	Aarylau Pahow	٥ľ	Marry Land Coord		y, Town or Lo	cation				1	0d. Inside City Limits 1 XYes 2 No
	284-1	rect	Maryland Cecil  10e. Street and Number	<u>P</u>	1kton	10f. Zip Code			10g. Cit	izen of What Cour	
	th with	ai Di	107 Gilpin Avenu	e		21921				ited Sta	•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mentel Hyglene. Important: if item 27 is marked other than "netural", or iteme 23e or 28e-f ahow expiritury or other traumatic avant, the Medical Examinar must be notified at anone.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1	Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 No	ian, Mexican, F	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Americ Black, White, Specify:	
9-0	72 hou	ted	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occu	pation		16b. K	ind of Business/In	
21	ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire					
121	iled w Hygier ther ti nt, th		17. Father's Name (First, Middle, Last)	12	Dir	ector of	T	tion Name (First, Midd		County Go	vernment
and	id be i entel l kad o	To Be	Herman Dixon					ah Loller		Sumame)	
ary	and Maria mar	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Street		or Rural Route Nur		or Town, State, Zip	Code)
∑ ``	s 1 and 2 of Health a item 27 is other trace	1	Kevin A. Boulden				E1kton,	, Marylan	_		
Baltimore, Maryland 21215-0036	ages 1 ant of H it: if its y or ot		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State Nor	th Eas	sition (Name of matory or other pla t Method		ugust 25,		ocation - City or To	
altir	permit. P Depertme importan eny injur		21. Signature of Funeral Service License		etery	. Name and Addre					Maryland
_	8858		Donaed S.	theeker.		3 W. Sto	ockton	unerals, Street,	Elkto	n, Maryla	and 21921
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death e cause on each line.  Due to (or as a conseq	ia	er the mode of dyi	ng, such as ca	rdiac or respiratory	arrest,		Approximate fnterval Between Onset and Death
18760,	The law requires that the death certificate be executed in the bear signed by the ettending physicien and in agge 2 should be deteched for use as the burial-transit in the contract of the contract in the co	dical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	uence of):						
P.O. Box 6	that the death certifice ed by the ettending ph deteched for use es ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 20 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3□	Ectopic pregnanc Other (specify)	у			23d. Date of delive Month	ory Day Year
	w requires that bean signed b should be deta	þ	Part II. Other significant conditions con-	tnbuting to death but not resi	ulting in the u	nderlying cause gr	ven in Part I.		d tobacco u	use contribute to the	e cause of death?
Division of Vital Records,	; The law r cete hes be ; page 2 sh	Completed						24a. Wi au pe 1  Yes	topsy rformed?	prior to cor death?	osy findings available inpletion of cause of
Ę	rsiclan; Th s certificete director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	ED/Out-stice	Ott		Death (Check onl			
ion of	To the Hospital or Attending Physician: The within 24 hours elier death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	ation: T	27. Manner of Death  11 Autural  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		ng Home 5 Re 28d. Describ			")
Divis	tal or Attanders seiter deatles Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location City or 7	(Street an	d Number or Rura )	l Route Number,
	To the Hospital within 24 hours of To the Funeral completely filled	edicai	one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tile restigation, in my o	me, date and popinion, death	place, and due to the control occurred at the time	e cause(s) e, date and	and manner as st place, and due to	ated. the cause(s)
	To To	Σ	29b. Signature and title of certifier			29c. Licens	se number	116	29d. Dai	te signed (Month,	Dey, Year)
	^		1 Jerua,	molecular and a second	020) (7		0)/	4	Au	gns/2	3,2006
	13		30. Name and address of person who con	The second cause of death (Item	23a) (Type,	SAICE	e/kt	on, r	1P		,
	Sta Registr		31 Date filed (Morths Pay, Moard 200	32 Registrar's Signa	1 6	and the	- /-		4		

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2006 For State Registra Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month 8/6/2006 Ζ. **Physician** Trma Berman 11:30RM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Kensington Parkway Retirement Com. Montgomery Kensington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | North | Days | Hours | Min. | 1 / (1.311/1.109/2.2) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 220-03-2991 1 ☐ M 2 💢 F 86 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits or itame 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Montgomery Kensington Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20895 3616 Littledale Road U.S.A. by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify White 3 ₩ Widowed 4 Divorced "neturei", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home I Hygie permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any lijury or other traumatic event, page. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sarah Baddock Emanue 1 Hurwitz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sherry Berman - Daughter 32815 Almwick Lane Lewes Delaware 19958 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial 8/10/2006 Falls Church VA 21. Signature of Funs. rvioc Licensee Edward Sagel Funeral Direction Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Throat Cancer /Medical Due to (or as a consequence of) Examiner Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Hypertension end Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical Anemia IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the ette in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 X Yes 2 No 3 Probably 4 Unknown COPD page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy certificate 1 Yes 2X No director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Assisted 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Living 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funaral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of cartific 29d. Date signed (Month, Day, Year) 29c. License number D53691 8/8/2006 of person who completed cause of death (Item 23a) (Type, Print) Ajay Reddy ND 6320 Democracy Boulevard Bethesda MD 20817 31. Date filed (Month 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician August 10, 2006 ам 6:58 Parkinson Baxa /Medical 4c. County of Death 4h City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Collinsqwood Nursing & Rehab. Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M **X**⊠ F Yrs. Director 015-03-0136 Massachusetts Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. Count r than "natural", or items 23a or 28a-f ehov Tre Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No Maryland Montgomery Rockville Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 299 Hurley Avenue 20850 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Specify:White Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Chain 8 Head Cashier 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil timent of Health and Mental H tant: If Item 27 is marked oil jury or other treumatic even Be John Parkinson Beatrice Helliwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other tree 13991 West Annapolis Ct., Mt. Airy, MD 21771 Kimberley Young/ Granddaughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Aug. 14 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2006 Rockville, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. علحط 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Renal Failure /Medical Due to (or as a consequence of): Examiner Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hypertension The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical SE IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year ō 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f o 9 Unknown 9 Tlinknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 Tes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2[] No 1 Yes 1 Tyes 2 **□**7No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛂 No 2 ER/Outpatient 3 DOA ţ. After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 2 Accident within 24 hours after dea To the Funeral Directo completely filled in by th 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 (X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 11, 2006 D30132 M-() 10 o completed cause of death (Item 23a) (Type, Print) M.d 14812 Physicians Lane, #161, Rockville, MD 20850

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month Pay Year) 1

32. Registrar's Signature

			1 - For State Registrar	State of Maryland	d / Depa		Health a		ntal Hvgi	_	
			1. Decedent's Name (First, Middle, Las	t)				2.	Date of Death Month	Day Ye	3. Time of Death
	Physici /Medi		CARL DENNISTON BA	LLANTYNE				ΑU		, 2006	1:20 AM
Section 2	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of	Death		4c. County of D	Death
			WASHINGTON ADVENTI	ST HOSPITAL		TAKO	MA PARK			MONTGO	MERY
	Funeral		Social Security Number     6. S	7. Age (In yrs. la		If Under 1 Year Months Days		4 Hrs. 8. Min.	Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
(6)	Director		117-54-0330	55	Yrs.				UNE 21,		AINT VINCENT, W.I.
	pur »	] }	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits
	ehow	5	MARYLAND PRINCE GEO			HYATTSVIL	TD				1 ☐ Yes 2 ☒ No
	Ne N	ecte	10e. Street and Number	JUGE 2		10f. Zip Code			10	g. Citizen of What	t Country?
	with or	ă							'`		
	be filed within 72 hours after death with the Maryland tial Hygiane. Id other than "naturel", or items 23e or 28e-1 ehow other than "naturel", or items 23e or 28e-1 ehow event. I're Medical Exam writinal te notified at	Funeral Director	1011 CONSIDERATION	ANE 12. Was Decedent Ever in U.S	13		785 Hispanic Origi	in? (Specif	v Yes or No-	SAINT VINC	ENT, W.I.
	Hem	Š	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	, 10.	Was Decedent of If Yes, specify Cul	ban, Mexican,	Puerto Ric	an, etc.)		Vhite, etc.
36	f, or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1∐Yes 2⊠ No	Specify:			Specify:	BLACK
21215-0036	ture cale	ed	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occu	pation		1	6b. Kind of Busine	ess/Industry
15	n 7	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Give life.	kind of work done DO NOT use retire	e during most ed)	of working			
212	r the	E	Eletteritary/Secondary (0-12)	4		BUYER				HOWARD UNI	VERSITY
	illed Hygi other	Bec	17. Father's Name (First, Middle, Last)				18. Mother	's Name (F	irst, Middle, N	laiden Surname)	
a	lid be	To B	JAMES CYRUS				I	SOLA E	BALLANTYN	E	
Maryland	2 should be filed withir and Mental Hygiane. is marked other than reumatic event, the Ma		19a. Informant's Name/Relationship (	Гуре, Print)	19b. Maili	ng Address (Stree	t and Number	or Rural F	Route Number,	City or Town, Sta	te, Zip Code)
	atth a		DAWN G. BALLANTYNE -	WIFE	1011 C	ONSIDERATI	ON LANE,	HYATI	SVILLE,	MARYLAND 2	.0785
Baltimore,	permit. Pages 1 and 2 should Depertment of Heatth and Men importent: if item 27 is marke eny injury or other treumstic once.		20a. Method of Disposition	CO.	ace of Dispo	osition (Name of matory or other pla	ace)	Dat	θ 2	Oc. Location - City	y or Town, State
E	Page III	ł	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification )	Hemoval from State				UG. 12	2006	ADELPHI, MA	ARYLAND
alti	permit. Pag Depertment Importent: I eny injury o		21. Signature of Funeral Service Licer							FUNERAL H	
ä	Depermine Depermine timpor in police.		None A.	Vacant							MARYLAND 20904
	Physician /Medical		23a. Part 1. Enter the disease, or com shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on each line.  a. Due to (or as a consequ	θ	ter the mode of dy	cing, such as c		espiratory arre		Approximate Interval Between Onset and Death 6 Mon M
,092	eath certificate be executed an attending physicien and for use as the buriat-transit of	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence)							
89	ng ph as th	Med	IF FEMALE:								
P.O. Box	requires that the death certificat een signed by the attending phy nould be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar  1 Live birth 2 Fetal  4 Pregnant at time of de  9 Unknown	death 3	□Ectopic pregnan □ Other (specify)	су			23d. Date of Month	f delivery Day Year
	w requires that been signed to should be det	þ	Part II. Other significant conditions of	ontributing to death but not resu	Iting in the u	inderlying cause g	iven in Part I.				te to the cause of death?  Probably 4Unknown
l Records,	The law ate hes b page 2 st	Completed							24a. Was ar autops perform 1 Yes 2	prior deat	e autopsy findings available r to completion of cause of th? Yes 2 ☑ No
ita	sien: ertific ctor,	Be (	25. Was case referred to medical examiner?					of Death (	Check only on	э)	
>	Physicien: this certific ral director,	10	1 ☐ Yes 2 ☑ No		ER/Outpatie	nt 3□ DOA O	ther: 4 🗆 Nur	sing Home	5 🗆 Reside	nce 6 Other (	Specify)
0	ng Pl fter tl mera		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	W			d. Describe ho	w injury occurred	
0	ending sath. or: After he funer	att	2 Accident investigation			M 1[	]Yes 2∐N	lo			
Division of Vital	irect irect	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, st	reet, factory, office	9	28	f. Location (Sti City or Town		or Rural Route Number,
	To the Hospitel or Attending PP within 24 hours effer death. To the Funerel Director: Affer the completely filled in by the funeral	Medical Ce	(Check only 2 Medical Exam	ysician: To the best of my knowniner: On the basis of examinate	wledge, deat	th occurred at the	time, date and	place, and	d due to the ca at the time, da	use(s) and manne ite and place, and	er as stated. due to the cause(s)
	the the mplet	Wed	29b. Signature and title of certifier	and manner stated.		29c Licer	nse number		20	d. Date signed (N	Month, Day, Year)
	5 × 5 0			) CLOW		T)	0 /	20		8/5/	OK
			1 1				2010	7		3/-/	-0
	10		30. Name and address of person who	completed cause of death (Item	23a) (Type,	, Print)	7 -	. /			Park mb.
2	/ ·		31. Date filed (Month Day Year)	32. Registrar's Signat	ure	1610	ANNO	1_19	VE. 1	Akong	TANK, MD.
	St Regist	ate rar	31. Date filed (Month Day Year)	2006	J. A	arte					

State of Manyland / Department of Health and Mental Hygien A C C

		1 - State Registrar	State of Marylar	Cer	tificate of l	Death		Reg. No.	
Physici	an	1. Decedent's Name (First, Middle, Las Walter J.	® Biesiada	a Jr			2. Date of De Month	Day Yea	3. Time of Death
/Media	cal	4a. Fecility Name (If not institution, give		a OL	4b. City, Town, or	Location of Dear	August	4c. County of De	
Examir	ıer	207 Oakdale Driv			Salish	oury		Wicomi	co
Funeral Director		5. Social Security Number 6. S 076-42-8631	7. Age (In yrs. 55	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			linthplece (State or Forei Country) Iew_York
A w		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limit
1	tor	Maryland Wicom	ico	Salisbu	ry				1X Yes 2 □ N
Department of regular and wenter hypered. Important: If Items 23a or 28a-f show important: If Item 27 Is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Mucical Examiner must be notified at ances.	al Director	10e. Street and Number 207 Oakdale Dri	ve		10f. Zip Code 21804			10g. Citizen of What USA	Country?
ams Brine	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No to Rican, etc.)	o- 14. Race - Ar Black, Wi	nerican Indian, hite, etc.
raf, or h	Completed by Fu	t ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	t [] Yes <b>X</b> [] No If Yes, Give Year or Dates:			Specify:		Specify:	white
"natı	iete	15. Decedent's Ed (Specify only highest gra		16a. Deced	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of wo	orking	16b. Kind of Busines	ss/Industry
than the M	dmc	Elementary/Secondary (0-12)	College (1-4or 5+) 4		ied Publ:			Accoun	ting
other.	Be C	17. Father's Name (First, Middle, Last)	<del>-</del>			18. Mother's Na	me (First, Middle	, Maiden Sumame)	
atic e	To B	Walter J. Biesiad	a Sr.			Anne M	arie Gol	Lembeski	
n 27 la me er traume		19a. Informant's Name/Relationship ( William P. Biesi	The second secon					er, City or Town, State and Heights	3, Zip Code) 3, MO 63043
Important: If Item 27 is any injury or other tra <u>pncs.</u>		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specification)	Removal from State	cemetery, crer	sition (Name of natory or other place Cremator		Date 1/06	20c. Location - City Salisbury	
any injur		2) Signature of Funeral Service Licer	see	22	. Name and Addres	ss of Facility Funeral	Home Pr	rofessional sbury, MD 2	Associatio
811		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	olications that caused the dea						Approximate Interval Between
cian		Immediate Cause (Final disease or condition	one cause on each nile.		ASCV	D			Onset and Death
dical niner		resulting in death)	Due to (or as a consec	quence of):					
imer	٠,	Sequentially list conditions,	b. Due to (or as a consec	Suppose of):					
nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events	Due to (or as a consec	querice or).					
as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
physic the bi	edical		d						-
or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1□Live birth 2□Fet	atdeath 3□	Ectopic pregnancy			23d. Date of o	delivery Day Year
detached for use	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of of the second of the	ueatn 5	Other (specify)				
5, 8	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause give	en in Part I.			to the cause of death? Frobably 4 DUnknow
s been si 2 should l	Completed						24a. Was	an 24b. Were	autopsy findings availab o completion of cause of
page 2	mo.						perf	ormed?	
director, pag	Be	25. Was case referred to medical examiner?					ath (Check only		
ō	P	1 ☑ Yes 2 ☐ No	Hospital: 1 Inpatient 2	-				idence 6 Other (S)	oecify)
the funeral	on	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe	how injury occurred	
in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		nome, farm, str		165 2 140		Street and Number or wn, State)	Rural Route Number,
completely filled in by		29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of my kn	owledge death	D occurred at the tin	ne, date and plac	a and due to the	rensem bos (a) sauso	as stated
etely	edical		niner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	pinion, death occ	urred at the time.	date and place, and d	ue to the cause(s)
complet	Be	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mo	nth, Dey, Year)
B	1	) ( Sw)			451	5497		8/10/06	
5		30. Name and address of person who				a 3 ! ·		4 4	
			Snyder, 100 E		oll St.,	Salisbur	y, MD 2	T80T	
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign		1 00				
Regist	_	AUG 14	2006 Maries	15. 4	TORES!				
110V 1/4	-001			2					

ORIGINAL

06-05871 Ma

#### Please Type or Print in Black Indelible Ink

arvin Blake	State of Maryland / Department of H  1- For State  Certificate of D		giene Reg No 200	6 2712
Physician/ ledical Examiner		2	2. Date of Death Month Day Year August 8, 2006	3. Time of Death 0202 hrs
1	Civista Medical Center L	City, Town, or Location of Death a Plata	4c. County of Death Charles	
Funeral Director	235-23-2242 1XM 2F 29 Yrs.	If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	8 Date of Birth (MM/DD/YYYY) 9. Bir Foreig AUG • 6 , 1 9 7 7 Co	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 Never Married  2 Married  3 Widowed  4 Divorced of Pyes, Give Year  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  MARVIN LEE BLAKE, SR.  19a. Informant's Name/Relationship (Type, Print)  MILLISA A. BLAKE-SPOUSE  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify  12. Was Decedent Ever in U.S.  Armed Forces?  14. Yes, Sive Year  15. Ves College (1-4 or 5+)  15a. Decedent's Information of College (1-4 or 5+)  15a. Decedent's Information of College (1-4 or 5+)  15b. Mailing Accordance of Disposition  1 Burial 2 Cremation 3 Removal from State  17c. Vas Decedent Ever in U.S.  17c. Vas Decedent Ever in U.S.	20646  ecedent of Hispanic Origin? (Spespecify Cuban, Mexican, Puerto Res 2 X No specify.  Usual Occupation (Give kind of wording life, DO NOT use retires Res 18.Mother's Name (LORI Beddress (Street and Number or Research	white, etc.  Specify WHI  srk done 16b. Kind of Business/ld)	ican Indian, Black,  TE Industry  ITRIBUTORS  7, Zip Code)  A MD 20646  Town, State
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each life.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Last Cause that caused the death. Do not enter the failure. Do not enter the failure. Last Cause that caused the death. Do not enter the failure. Last caused the death. Last caused	A PLATA, MARYL mode of dying, such as cardiac or	AND 20646 respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
be exe sician a urial -	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  AMENDED  item#1, 23a, 27, perf  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal 4 Pregnant at time of death 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the und	death 3 Ectopic pregnan	cy 23d. Date of deliver  Month I  23e. Did tobacco use contribute to	Day Year
tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach Be Completed by P	Of Was accomplished to modical	26 Place of Death (Check o	autopsy performed? death?  1 ✓ Yes 2 No 1 ✓ Yes	utopsy findings available completion of cause of
sion of Vil utending Physic death ctor: After this y the funeral dir	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	B DOA Other4 Nursing ry 28c. Injury at Work? : 1 Yes 2 No	Home 5 Residence 6 Othe 28d. Describe how injury occurred 28f Location (Street and Number or Ruor Town, State)	
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in B Medical Certifit			due to the cause(s) and manner as star	
To T	Paneth Bruthad, MC	29c License number O.C.M.E.	29d Date signed (Mc August 9, 2006	inth, Day Year)
Stat	20 Partition Circulus	nn Street, Baltimore, MD 2	21201	

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AUGUST MARTHA T CLINE 2006 8:22 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK | HUnder 1 Year | HUnder 24 Hrs. | 8. Date of Birth | 9. Birthplace (Sta Months | Days | Hours | Min. | Feb. 22, 1929 | Macultum | M 5. Social Security Number 7. Age (In yrs. last birthday)
77 Yrs. 9. Birthplace (State or Foreign **Funeral** Months 218-24-0079 1 □ M 2 💢 F Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Maryland Frederick Walkersville 1 ☐ Yes 2X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8761 Treasure Ave. 21793 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No þ Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fil tment of Health and Mental H tant: if item 27 is marked otl Paul Streams Catherine Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin A. Cline, husband 8761 Treasure Ave., Walkersville, MD 21793 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H important: if its eny injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State Mount Olivet Cemetery Aug. 25, 2006 Frederick, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Keenev and Basford PA Funeral Home Richarde M00255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence physicien and s the burial-transit certificate be executed Due to (or as a consequence of) Physician/Medical use as signed by the attending I be detached for use as 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23b. Was decedent pregnant in the past 12 months?
1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) 23d. Date of delivery 3 DEctopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. à 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an s certificate has tirector, page 2 s autopsy performed? Yes 22 No 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဥ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA spital or Atteriding Physical cours efter death.
nerel Director: After this filled in by the tuneral di 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 10 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funerel I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D43091 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOLL Hove Are Frederich MD MM Sacred 801 31. Date fifed (Month, Day, Year) 32 egistrar's Signa State Registrar AUG 2 8 2006

					Maryland/ Inf © 10/	Pepa Cei	artmen H rtificat	t of H	lealth a	and M			06	27122
	Physici	an	1. Decedent's Name (First, Midd								2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	CATHERINE S.  4a. Facility Name (If not institution		mher)		4h City	Town or	r Location o	of Death	AUGUST	12 4c. Count	2006	6:15PM <sup>M</sup>
	Examin	er	8195 LAUREL L					ENTO		or Dodan			LINE	
F	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last b.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	lace (State or Foreign
	Director		156-03-1937 Usual Residence of Decedent	1 □ M 2 <b>X</b> F	85	Yrs.					APR 27	, 1921		TLAND
	/land			urlingtan	10c. City, Tov	wn or Lo	cation						1	0d. Inside City Limits
	e Mar	ctor		ROLINE	Ð	ENT	N	South	<b>hampto</b>	n				Yes 25No
	vith th	Funerai Director	10e. Street and Number	10 77			10f. Zip			000		10g. Citizen of		ntry?
	s 23s	erai	8195 LAUREL L		edent Ever in U.S.	13 1	Was Decer		21629			14 Ra	USA ce · Americ	ean Indian
ယ္	72 hours after death with the Maryland naturel; or items 23a or 28a-f show Iteal Examiner must be notitled at		1 ☐ Never Married 2 ☐ Mai	Armed Formed I ☐ Yes	orces? 2 ANo						cify Yes or No- Rican, etc.)	Bla	ick, White,	
903	rel', c	d by	3 XWidowed 4 □ Divorce	d If Yes, Gi Year or E	ve Dates:		1 🗆 Yes	2 🔼 No	Specify:			Specii	y: WH]	ITE
5-(	"natu	ete		nt's Education est grade completed)		Give	kind of wo	al Occup	ation during mos	t of workin	ng	16b. Kind of B	Business/In	dustry
21215-0036	filed withln Hyglene. other than " ent. Ine Mes	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)		1EMAK		-/			OWN H	HOME	
	e filed al Hygi i other vent.	BeC	12. Father's Name (First, Middle						18. Mothe	er's Name	(First, Middle,	Maiden Sumai	me)	
yla	should be nd Mental marked o	To	DAVID SHARP								NE SMIT			
Maryland	0 0 0		19a. Informant's Name/Relation								/ Route Numbe		, State, Zip	(Code)
	Health tem 27 tother tra		NANCY C. BRENN 20a. Method of Disposition	AN/DAUGHT	20b. Place	of Dispo	sition (Nar	ne of			ON, MD	21029 20c. Location	- City or To	own, State
altimore,	8° = 5		1 ☐ Burial 2 X Cremation 1 ☐ Donation 5 ☐ Other (		State	•	natory`or o			TR 8	/14/200	6 STEVE	ENSVII	LLE, MD
Balti	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service	Licensee	REA						& NEWN EASTON,			HOME PA
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that	caused the death. Do	not ent	er the mod	le of dyin	ng, such as	cardiac o	r respiratory arr	rest,		Approximate Interval Between
	Priysician	4	Immediate Cause (Final disease or condition resulting in death)	aS	EPSIS									Onset and Death
	/Medical Examiner		resulting in death)	Due to	or as a consequence		1-1-1	20.0	7 5	· 1.11	URE			Flore
	ID MUE	Jer	Sequentially list conditions, 1 any, leading to infraedate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a consequence		110	1112	-( -	MIL	Dree .			, cays
	cuted nd transit	Examin	that initiated events	C										
8760,	be executed sicien and burial-transit	i Ex	resulting in death) Last	Due to	(or as a consequence	of):								
687	physicate physicate	edicai		d										
ŏ	death certificate be executed e attending physicien and ad for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		itcome of pregnancy birth 2   Fetal deat	b 2	Ectopic pr	·000000				23d. Da	ate of delive	*
Э. В	e deat he atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		nant at time of death		Other (sp					Me	onth	Day Year
P.0	The law requires that the de ate has been signed by the bage 2 should be delached		Part II. Other significant condit	ions contributing to a	leath but not resulting	in the u	nderlying c	ause civ	en in Part I		23e. Did to	bacco use con	tribute to th	ne cause of death?
Records,	uires l signe ld be	d by		,	<b>-</b>		,	g		-	1 🗆 Y	es 2 No	3 Prob	ably 4 Unknown
00	law requas been 2 should	ojete									24a. Was a		Were auto	psy findings available
Re	i: The la icate ha	Completed									autop: perfor	med?	death?	mpletion of cause of
Vital	Physiclen: this certific ral director,	Be (	25. Was case referred to medical examiner?							of Death	(Check only or	_		Daughter's
of		To.	1 Yes 2 No	Hospital: 1  28a. Date	Inpatient 2 ER/O	utpatier Time of		Oth 28c. Injur	4 🗆 🛚 🗓		ne <b>52 h</b> aid 28d. Describe h			» Residence
lon	Attending F r death. actor: After by the funer	ation	1 Matural 5 ☐ Pend		nth, Day Year)	Injury	М	Wor	k? Yes 2 □			,,		
Division		Certification;	3 Suicide 6 Could 4 Homicide deter	mined 286. Place	e of Injury - At home, t ling, etc. (Specify)	farm, str	eet, factory	, office		2	28f. Location (S City or Tow	treet and Numi	ber or Rura	d Route Number,
Ō	urs after orei Direction													
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edicai		I Examiner: On the b	e best of my knowledg pasis of examination a nner stated.									
	To the within 2 To the complet	Me	29b. Signature and title of certifi		/ . /		290	c. Licens	e number		2	29d. Date signs	ed (Month,	Day, Year)
			> AHI	Cona	W		E	1004	1416			AUGUST	12,	2006
	5-		30. Name and dress of person										1.7-5.6	
	Sta	to	JOHN R. CONDI' 31. Date filed (Month, Day, Year	T, JR. DO	522 IDLEW egistrar's Signature	LLD	AVE.,	EAS	STON,	MD 2	1601			
	Registr		AUG 1 4		and the			5						

State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Year 2043 LUCY K. CUSTIS 09 06 08 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HICOMICO 30/15/14 Teninsula REGIONAL Medical If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 M 2 X Country) VA 218-16-7823 97 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No VA Mappsville Accomack 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29130 Turkey Run Rd. 23407 USA items 23a 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 1 ☐ Yes 2 ☐ No þ Specify: Black 3 ☐Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiena. other than " College (1-4or 5+) Elementary/Secondary (0-12) Educator School School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill thent of Health and Mental H tant: If Item 27 Is marked other Be Isaac Knox Martha Dickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) parmit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other treu Sallye B. Carter, Niece 1004 E. Cold Spring Ln., Baltimore, MD 21212 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐RemovaLfrom State First Bapt. Cemetery 08/19/06 1 4 □ Donation 5 □ Other (5) Mappsville, VA 21. Signature of Funeral Ser 22. Name and Address of Facility Cooper & Humbles Funeral Co., Accomac, VA that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part . Enter the disc as Approximate Interval Between Onset and Death mmediate Cause (Final Physici an disease or condition resulting in death) /Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last is a conseque Examiner physician and the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be exacuted Due to (or as a consequence of): Box 68760, Physician/Medical use as I IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy ŏ Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Certification: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 1 Yes 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No hours after deal 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ determined 4 Homicide Vithin 24 hours are To the Funeral Div Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAIN ENG 100 E. SIMONA D.O. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 1 5 2008

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 22, 2006 6:05AMM DE BINDER MILDRED MARGUERITE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHARLES CHARLES COUNTY NURSING & LA PLATA REHAB. 7. Age (In yrs. last binhday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🂢 F 96 579-44-3691 Director JAN.10,1910 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at XXYes 2 No Director MARYLAND CHARLES LA PLATA 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20646 10200 LA PLATA ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3.☐Widowed 4 ☐ Divorced þ ieted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME UNKNOWN HOMEMAKER ulth and Mental Hygie 27 is marked other r traumatic event. other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DAVID MERRITT GAINES IDA LOUISE RAMSEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Heelth and Important: If Item 27 ts m any injury or other traum QDCs. DEBORAH WHITE-GRANDDAUGHTER 9850 LOMAX RD., FAULKNER, MD 20632 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 4 ☐Donation 5 ☐ Other (Specify) BALTIMORE NATIONAL CEM. 8-24-0 BALTIMORE, MD 21. Signature of Funeral Service Licensee 7922. Name and Addro RAYMOND FUNERAL SERVICE, A PLATA, MARYLAND has cardiac or respira 20646 23a. Part1. Enter the disease, or complications that aused the death. shock, or heart failure. List only one cause on each light. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or use as the burial-transit be executed Exami that initiated events and resulting in death) Last Due to (or as a consequence of): Physician/Medical attending phys IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the t 1 ☐ Yes 2 ☐ No Ó 9 Unknown 9 Unknown signed by the ے 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No certificate of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Medical Certification: Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. filled in by the fu 2 Accident 6 Could not be determined 3 TSuicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō within 24 hours e To the Funeral I completely filled To the Hospital 29a. Certifier 1 Contifying Physiciam: To the best of my knowledge, death occurred at the time, date and offers and dive to the natural(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier 225 MP use of death (Item 23a) (Type, Print) 30. Name and address of person who enter#302 11 CIMP o ad line -Uber 2000 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 2 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006

				State of Ma	ryland /	Certii	ment of r ficate of	Death	иепіаі пу	Reg. No. 20	06 2	27125
	Physici /Medic		Decedent's Name (First, Middle, Last)     Rosebud	Cathe	rine		Dooley		2. Date of De Month August	ь 8 200	Year	Time of Death ':45 pm
	Examir Funeral Director		4e Fecility Neme (If not institution, give stress 527 Norton Lane 5. Social Security Number 6. Sex 072-22-9659		(In yrs. lest t		f Under 1 Year lonths Days	4b. City, Town, or L  Arnold  If Under 24 Hrs.  Hours Min.	8. Date of Bir (Month, Da Jan 17	Anne	e Arund	(State or Foreign
	D		Usuel Residence of Decedent  10a. State 10b. County	Į.	10c. City, To	wn or Locati			Jour 17		10d. lr	nside City Limits □ Yes 2771740
	with the Me a or 28s-fs	Funeral Director	MD Harfore  10e. Street end Number  3101 A Cardinal War		Abi	Ingdon	10f. Zip Code	1009		10g. Citizen of W	hat Country?	
720	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Depertment of Heelih and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ		. Wes Decedent E Armed Forces? 1 ☐ Yes 2 2 3 No If Yes, Give Year or Dates:	ver in U,S.			Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)		- American In c, White, etc. Whit	
Maryland 21215-0020	within 72 hou ene. then "nature he Medicel E	Completed	15. Decedent's Educe (Specify only highest grade		-)	(Give kind life. DO	t's Usual Occur d of work done NOT use retire	during most of word d)	king	16b. Kind of Bu	ga*	
yland z	uld be filed Mentel Hygi irked other atic event, i	To Be Co	17. Father's Neme (First, Middle, Last)  John Collins						,	Maiden Sumame chem	9)	
e, Mar	1 end 2 sho 1eelth end I Im 27 is me ther traume	-	19a. Informant's Name/Relationship (Type Patricia A. Lawlor 20a. Method of Disposition		r) 5	527 No	rton La	and Number or Ru ane, Arno		er, City or Town, \$21012  20c. Location - 6		
altimore,	iit. Peges ' srtment of h ortant: if its injury or of	1	1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service-Licensee			Land V	on (Name of ory or other ple Tet. Cet ame and Addre	n.	8-14- 2006	Crownsv		
E E	Depermination of the second se		13-2.4		the death. Do	1	2 Ridge	ess of Facility Funeral Ly Avenu	e, Annap	polis, M	App	roximate
	Physician /Medical Examiner	16	23a. Pert1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in deeth)	net	a st	ax	il	ng C			Ons	rval Between et and Death
	certificate be executed rding physician and use es the bunel-trensit	n/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		oue to (or as a							
л Э	v requires thet the deeth certif been signed by the attending should be deteched for use e	/ Physician/M	Part II. Other significant conditions control	ibuting to deeth but	t not resulting	in the unde	orlying cause gi	ven in Part I.		tobacco use con Yes 2□ No	1	cause of death?
or vital Records,	2 00	Completed by							24a. Was	an autopsy ormed?	availabl	utopsy findings e prior to tion of cause 1?
Ital H	두 뚫음	Be Con	25. Was case referred to medical examiner?					26. Plece of Dea	1 □	/ \		2 □ No
ion of v	5 00	၉	27. Manner of Deeth 1 Natural 5 Pending 2 Accident rivestigation	spitel: 1 □ Inpatien 28a. Date of Injury (Month, Dey	/ 28b	Outpatient Time of Injury	28c. Inju		ome 5 ☐ Resi 28d. Describe	dence 6 XOthe how injury occurre		aughter's esidence
Division	oltal or Attanding I urs efter death. vrai Director: After illed in by the fune	I Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injurbuilding, etc.	(Specify)				City or To			
	To the Hospital or Attanding Phywithin 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral	Medical	29a. Certifier (check only one)  29b. Signature and title of certifier	r: On the best of and manner stat	exemination e	ge, death 60 end/or inves	tigation, in my	me, date and place opinion, death occu	red at the time,	date and place, a	ind due to the	cause(s)
	4		30. Name and eddress of person who con	pleted cause of de	ath (Item 236	(Type, Pri	) exp	ISE A	478	ANNA	aven w	1021401
	Sta Regist		31. Date filed (Month, Dey, Year)  AUG 1 1 200	32 Registre	r's Signature	A.a.	AP	J- 1/10	ny	1 101014	<u> </u>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 23a Line a per ML, 8808, 625/07 II

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	Physici	an	Decedent's Nam							2. Date Mon	of Death th	Day	Year	3. Time of Death
	/Medi				Dashiell					Aug			006	10:00 PM
1	Examir	ner	4a. Fecility Name		give street and i	number)			n, or Location of	Death		4c. County		
			122 Fir		C C	7 A== //=	um last bloth day	Salis		4 Hrs   0 Date	of Diah	Wico	omico	
	Funeral		5. Social Security I 214-28-8		6. Sex 1 ☐ M 2007 F		yrs. last birthday)  A Yrs.	Months Da		Min. (Mon	th, Day, Ye			ace (State or Foreign try)
	Director		Usuel Residence			7	4			Mar	21,1	932	ĪΛ	D
	land		10a. State	10b. County		100	c. City, Town or Lo	ocation					11	0d. Inside City Limits
	Mary	ţō	MD	Wicomi	ico		Salisbur	V'						1 <b>∑</b> Yes 2 ☐ No
	28a	Je C	10e. Street and Nu	ımber				10f. Zip Cod	e		10g.	Citizen of W	Vhat Coun	try?
	3a ou	O	122 Fir:	st St.				2180	1				USA	
	death with the Maryland ims 23a or 28a-f show finual by indiffed at	era	11. Marital Status		12. Was De	ecedent Ever	in U.S. 13.			in? (Specify Yes Puerto Rican, et	or No-		- Americ	an Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "naturat", or items 23a or 28a-f show other traumatic event, it a Medical Erani er must be indifficial at	by Funeral Director		ried 2 Marrio	ed 1 🗆 Ye	Forces? s 2 TNo Give Dates:		If Yes, specify C 1 ☐ Yes 2 🔀 f		Puerto Rican, et	c.)		k, White, o Blac	
ŏ	2 hou	Completed		15. Decedent	s Education		16a. Dece	dent's Usual Oc	cupation		16b	o. Kind of Bu	siness/Inc	dustry
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<u>a</u>	should be Ind Mental I	To E	Theodore	e Dashie	211				Anna	a Harris				
Maryland	and had is ma	'	19a. Informant's N	lame/Relationsh	ip (Type, Print)		19b. Maili	ng Address (Stre	et and Number	or Rural Route I	Vumber, Ci	ity or Town,	State, Zip	Code)
	alith 27 i		Adrika 1	E. Dashi	ell/son		9203	Applefo	ord Circ	cle, Apt	. 250	, Owir	ngs M	ills, MD
ore.	of He item		20a. Method of Dis	•	a 🗆 D 4 f	2	Ob. Place of Dispo cemetery, cre-	osition (Name of matory or other)	olace)	Date		. Location -		
Ĕ	Page nent int: If			5 ☐ Other (Sp	3 □Removal fro <i>ecify)</i>	III State	Green Ac:			/12/2006	Sa	lisbur	y, M	D
Baltimore,	permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traum 90.00.		21. Signature of F	uneral Service L	icensea		2	Name and Ad	dress of Facility					
m	Department		TOPA	1ACD	Walter	DA.				Funeral Salisbur				
100	0.016		23a. Part1. Enter shock, or he	the disease, or	complications tha	t caused the	death. Do not en	ter the mode of	tying, such as o	ardiac or respira	tory arrest,	21001		Approximate Interval Between
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¢.	/Medical		disease or conditi resulting in death)		a	to (or as a co	nsequence of):	avootherm		— complic hyperthem		у		527
	Examiner							JI		,	7			
_0		Jer	Sequentially list of if any, leading to it cause. Enter Und Cause (Disease o	onditions, mmediate	Due t	to (or as a co	nsequence of):		_	O PROVED BY MEDIC		ER .		
	cuted	Examiner	that initiated event	S	C.				11 ~	N DY MEDIC	AL EXAMINE			
o,	icate be executed physician and s the burial-transit	EX	resulting in death)	Last	Due	to (or as a co	nsequence of):		- SATION AP	ROVEDBI				
68760,	ate be nysici he bu	edicai		18	d			C	RIFIGHT					
89	eath certificate be executed attending physician and for use as the burial-transit	Ned	IE ECMAN C.											
Вох	The law requires that the death certif te has been signed by the attending age 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was deceded			outcome of pre-		Ectopic pregna	ncv				of delive	•
<u> </u>	the att	sicia	in the past 12	<b>™</b> No		gnant at time		Other (specify,				Mon	ith	Day Year
P.0	that the deed by the detached	h	9 🗆 Unknow											
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>	Physician: this certificatal director, I	To E	examiner? 1 □XYes <del>2€</del>	No	Hospital:	] Inpatient	2 ER/Outpatier	nt 3 DOA	Other: 4 Nur	sing Home 5 🖳	Residence	e 6 □Othe	r (Specify	)
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	I or Attending after death. Director: After I in by the fune	Medical Certification	2 X Accident 3 Suicide 4 Homicide  29a. Certifier (Check only)	1 Certifying	Physicien: To take	Home the best of my basis of exa	knowledge, deat	vestigation, in m	o time, date and y opinion, death ense number	122 Fi	rst St o the cause time, date	. Apt 7	nner as sta nd due to	sbury, MD ated. the cause(s)
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			1 - For State Of Maryland / I State Of Maryland / I Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. I	No.	3. Time of Death
	Physici /Medio		Michael Scott Everh		Aug 22, 20	06 8	3:55 pm м
	Examir	ner	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital	4b. City, Town, or Location of Do		4c. County of Death	
	Funeral Director		5. Social Security Number  6. Sex 7. Age (In yrs. last bit)  1. Age (In yrs. last bit)	thday) If Under 1 Year If Under 24 H Months Days Hours N		9. Birthplac MD try	e (State or Foreign )
	death with the Maryland me 23a or 28a-f show	ctor	10a. State 10b. County 10c. City, Tow	n or Location umberland			Inside City Limits 1 □XYes 2 □ No
	th with th	Funeral Director	10e. Street and Number 118 Columbia Street	10f. Zip Code 21502	10g. 4	Citizen of What Country USA	?
020	be filed within 72 hours after death with the Marylan lal Hygiene. Id other than "natural", or iteme 23a or 28a-f show event, the Maulical Examinar mank be calified at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates: 1968-74	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt  1  Yes  No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Black, White, etc	Indian,
1215-0036	within 72 hours after ene. than "natural", or ite	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)		. Kind of Business/Indus	
yland 21	be filed wi tal Hygien d other th	Be Con	17. Father's Name (First, Middle, Last)		Name (First, Middle, Maid		9
Лагуја		To		n. Mailing Address (Street and Number of 18 Columbia Street	ly (Slavin) M Rural Route Number, Cit Cumberl	y or Town, State, Zip Co	21502
Jore, I	Pages 1 and 2 should ment of Health and Mer ant: If item 27 is marke ury or other treumatic		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State	f Disposition (Name of ry, crematory or other place)	Date 20c.	Location - City or Town	
Бащтог	permit. Pag Department Important: eny injury once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	22. Name and Address of Facility Scarpelli Funeral	Home, P.A.	•	1410
iles:			23a/Pan1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	108 Virginia Aver	lue; Cumberiano diac or respiratory arrest,	A	pproximate terval Between
	Physician / Medicale pe executed / Medicale Examiner   Bubysicien and as the pural-transit	Examiner	Infmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. PULMONARY EMBC  Due to (or as a consequence of CORONARY ARTER DUE to (or as a consequence of CORONARY ARTER DUE to (or as a consequence of CORONARY ARTER DUE to (or as a consequence of CORONARY ARTER DUE to (or as a consequence of CORONARY ARTER DUE to (or as a consequence of CORONARY ARTER DUE to (or as a consequence of CORONARY ARTER DUE to (or	of):  CVA of):  Y DISEASE			
. Box 68/6U	ath cert	Physician/Medical	d	a 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Da	ay Year
s, P.O	Se Ligo	b	Part II. Other significant conditions contributing to death but not resulting	n the underlying cause given in Part I.		o use contribute to the	1.
cords,	requi	eted	DIABETES CHRONIC DENAL BALLUDE		1 Tes		
итан жес	The la ate has page 2	Completed	CHRONIC RENAL FAILURE  HYPERTENSION 25. Was case referred to medical	0.00	24a. Was an autopsy performed		
	Physicien: this certific al director,	To Be	examiner?  No Yes 2 No Hospital: 1 Inpatient 2 ER/O	Othon	Death Check only one one one one one one	6 ☐Other (Specify)	
DIVISION OF	ng Pt ter th	Certification:		Time of lnjury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
	To the Hospitet or Attendir within 24 hours after death. To the Funerel Director: All completely filled in by the fu		4 Homicide determined building, etc. (Specify)	•	City or Town, St		
	e Hosp 24 hou Fune etely fi	Medical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination at one)  2 Medical Examiner: On the basis of examination at one)	e, death occurred at the time, date and pl nd/or investigation, in my opinion, death o	lace, and due to the cause occurred at the time, date a	e(s) and manner as state and place, and due to th	ed. e cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number D09157	29d.   F70	Date signed (Month, Da	y, Year)
	4		30. Name and address of person who completed cause of death (Item 23a)  1. Date field (Month, Day, Year)  32. Registrar's Signature	(Type, Print) 24 W. 3rd Street Cun	nberland MD	21502	
10 m	Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 2 8 2006	Louis -			
DH	MH 17 Rev 1/2	2001		RIGINAL			

			For State	State of Ma		•		l Mental Hygi	iene	
			Registrar  1. Decedent's Name (First, Middle, Last			ertificate	or Death	2. Date of Deat	19. No. 2008	32m7 of b.28
12	Physici	an		llie Marie	Eston			Month	Day Year	
	/Media		4a. Facility Name (If not institution, give		raceb	4b City To	wn, or Location of De	August	12, 2006 4c. County of Dea	1:55 p M
	Examir	ier	1162 Ebenezer Chu				ising Sun		1	ecil
	Funeral		5. Social Security Number 6. S		e (In yrs. last birthd	ay) If Under 1	'ear   If Under 24 H	lrs. 8. Date of Birth	9. Bij	thplace (State or Foreign ountry)
	Director		214-24-9702	□M 2XF	85 Yrs	Months C	ays Hours M	oct. 31	, 1920 Wes	st Virginia
	D .		Usual Residence of Decedent							
	anylar ahow		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	Ba-f	octo	Maryland Ceci	11		1	Conowing			
	vith th	P	10e. Street and Number	D 3		10f. Zip Co		10	og. Citizen of What C	ountry?
	s 23a	eral	204 Conowingo Lak	e Road	Everin II S 1	3 Was Dacadan	21918	(Specify Ves or No.	14. Race - Am	
36	s 1 end 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28a-f ahow other traumatic avant, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Forces?  1 ☐ Yes 2 ♣ ↑  If Yes, Give  Year or Dates:	No	If Yes, specify		(Specify Yes or No- erto Rican, etc.)	Black, Whi	
21215-0036	2 hou	ed	15. Decedent's Ed	ducation	16a. De	cedent's Usual C	ocupation		16b. Kind of Business	/Industry
215	within 72 iene. then "na	Completed	(Specify only highest gra	College (1-4or 5	lif	ive kind of work on DO NOT use i	done during most of v etired)	vorking		
5	filed withi Hygiene. other then	E O	Eleven Years	0011090 (1 401 0		Hom	emaker		Personal	Residence
9	al Hygid I other	Be (	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle, M	faiden Surname)	
Maryland	2 should be i and Mental i is marked or aumatic ave	2	Lee	Welch				McCella Mc		
a	2 sh and Is m		19a. Informant's Name/Relationship (					Rural Route Number,		
0	1 end Health am 27 sther tr		Robert L. Estep	(son)	204 20b. Place of Di		-		ingo, Mary 20c. Location - City o	rland 21918
Baltimore,	if of the or of or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		cemetery, o	crematory or other	r place)			
Ë	t. Partmen		4 Donation 5 Other (Specif	, sales	Crest Law		Gardens 0	8/16/06 M	arriottsvi	lle,Maryland
Ba	permit. Pages 1 en Department of Heali Important: If Itam 2 any injury or other otice.		21. Signature of Funeral Service Licer	Janes V	JOI, 50	Lee A. Perryvi	Patterson	& Son Fune and 2190:	3-0766	T
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	pfications that caused one cause on each fi	I the death. Do not ne.	enter the mode o	f dying, such as card	iac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a	multi-11	ferct i	dementia			Sycars
	/Medical Examiner		resulting in death)		a consequence of):					
		L.	Sequentially list conditions,		erebrulas a consequence of):	cular ac	cident			syears
	per list	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		tunertens	ina				10 years
	xecu al-tra	xar	that initiated events resulting in death) Last	U	a consequence of):					1
68760,	icate be executed physicien and s the burial-transit	al		d						
687	tificate ig phy as the	edical		. u.						
D. Box	The law requires thet the death certif ite hes been signed by the attending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🖾 No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic preg 5 □ Other (speci			23d. Date of de Month	olivery Day Year
P.0	thet the	P.	Part II. Other significant conditions of	contributing to death b	ut not resulting in th	e underlying caus	se given in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
ds,	signed be det	1 by	•	• • • • • • • • • • • • • • • • • • •	•	, <b>g</b>	,	1 □ Ye		robably 4 Unknown
Š	w requir been si should	Completed						24a. Was ar	24h Wasa a	utangu findinga guadabla
3e	hes pe 2	ш						- autops	v prior to	utopsy findings available completion of cause of
_ 	ician: The l certificate he rector, page	e Co	25. Was case referred to medical					1 ☐ Yes 2		
of Vital Records,	ysician: is certific director,	00	examiner?  1 \sum Yes 2 \sum No	Hospitaf:	ent 2 ER/Outpa	tient 3 DOA		Death (Check only one	7	Facility
on of	두 두교	tion; To	27. Manner of Death  1 △ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da	ry 28b. Tim		Injury at Work?	28d. Describe ho		эспу)
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined		ury · At home, farm, c. (Specify)	street, factory, o	ffice	28f. Location (Str City or Town	reet and Number or R , State)	ural Route Number,
	Hospita 24 hours Funera	Medical C	29a. Certifier Control 2 Medical Example one)	niner: On the basis of and manner sta	f examination and/o	eath occurred at r investigation, in	he time, data and ple my opinion, death or	ace, and due to the ca courred at the time, da	uss(s) and in a mer a ate and place, and du	e to the cause(s)
	To the comple	Me	29b. Signature and title of certifier	Challe.		29c. L	icense number	29	ed. Date signed (Mon	th, Day, Year)
	1		30. Name and address of person who	completed cause of d	eath (Item 23a) (Ty	pe, Print)	+400	Aberdeen	MD 2100	0/
	1		31. Date filed (Month, Day, Year)		ar's Signature	100 3116				,
	Sta Regist	ate rar	AUG 1 5 2006	Kenne L	ar's Signature					

			For State Registrar	State of I	Maryland / [	Department of Certificate of			iene .g. No 20 (	06	271	29	
- A		. %	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day Year				
Physic /Med			Georgette E.		Eck		8		2006 1:10		Рм		
3	Examir		4a. Facility Name (If not institution		er)	4b. City, Town,	or Location of Death		4c. County	of Death			
×			834 Church Stre		A	Salisbu		10.5(8:11	1	omico	(0)	-	
*	Funeral		5. Social Security Number 167–34–0565	6. Sex 7. 1 ☐ M 2 ☐ F	Age (In yrs. last bir	Yrs. Months Days		8. Date of Birth (Month, Day,	Year)		ace (State or ry)		
	Director		Usual Residence of Decedent		84			1-6-192	Z <u>1</u> 5	altim	ore, M	1D	
	yland		10a. State 10b. County		10c. City, Tow	n or Location				10	d. Inside City	Limits	
	Mar.	to	MD Wicon	nico	Salish	ourv					1X Yes	2 🗌 No	
	th the	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of W	hat Count	ry?		
	23a	a	834 Church St.			21804			USA				
	iges 1 and 2 should be filed within 72 hours efter death with the Maryland to Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23s or 28s-f ehow or other traumatic event, in a Madical Exact and intelligation of the traumatic event, in a Madical Exact and intelligation.	by Funeral	11. Marital Status	12. Was Decede Armed Force	es?	<ol> <li>Was Decedent of If Yes, specify Cul</li> </ol>	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)					
36	s efte	Y FI	1 ☐ Never Married 2 ☐ Marri 3 🕅 Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 If Yes, Give Year or Date		1 ☐ Yes 2 🕅 No	Specify:		Specify	Whi	ce		
8	hour tural		15. Decedent			Decedent's Usual Occu	unation		16b Kind of Bu	siness/Indi	ustry		
15	in 72 n na	Completed	(Specify only highes	t grade completed)		(Give kind of work done life. DO NOT use retin	e during most of worked)	ang			,		
212	d with giene	E	Elementary/Secondary (0-12)	College (1-4 5+	01 5+)	Teacher			Public	Schoo	1		
שָׁכ	e filec othe vent,	Bec	17. Father's Name (First, Middle,	_ast)			18. Mother's Nam	e (First, Middle, M	Maiden Sumam	е)			
/lar	should be nd Mental marked c	To E	George Eckhard	lt, Jr.			Bernice	Emma Sei	lbert	14. Race - American Indian, Black, White, etc.  Specify: White  . Kind of Business/Industry  ublic School den Sumame) ert by or Town, State, Zip Code)			
Maryland 21215-0036	2 sho and I is mu	10	19a. Informant's Name/Relationsh	tip (Type, Print)	195	. Mailing Address (Stree	t and Number or Ru	ral Route Number,	, City or Town,	Baltimore, MD  10d. Inside City Limits 1 Yes 2 No en of What Country?  SA  4. Race - American Indian, Black, White, etc.  Specify: White d of Business/Industry  1ic School  Sumame) tt  Town, State, Zip Code)  04 eation - City or Town, State  Imar, DE 1 Home MD 21804  Approximate Interval Between Onset and Death  3d. Date of delivery Month Day Year			
	and and n 27		<u> Bernice Greene -</u>	- daughter		34 Church St		2.4					
ore	Pages 1 nent of Hi int: If iter iny or oth		20a. Method of Disposition 1 🗆 Burial 2 🗓 Cremation	3 ∏Removal from St	remete	f Disposition (Name of ry, crematory or other pla	ace)	Date	20c. Location -	City or Tov	in, State		
Ë	Pag tment tant: jury	i i	4 ☐ Donation 5 ☐ Other (Sp	pacify)		ory of Delr							
Baltimore,	permit. Pages Department of P Important: If its any injury or of		21. Signature of Funeral Service	icepsee	1/2	22. Name and Addr							
	405 • a		1/Klissu /	peny se	ne								
			23a. Part. Enter the disease, or shock, or heart failure. List	only one cause on eac	h line.	not enter the mode of dy	ing, such as cardiac	or respiratory arre	esi,		Interval Betw	/een	
	Physician		disease or condition resulting in death)  a. Introduction a. I										
	/Medical Examiner		rosuming in dodain,	Due to (or	as a consequence	of):		7					
		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequence	of):							
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Di	1. Ja	tillen	21 - 1	100 I	_				
Ť,	execu n and ial-tra	Exa	that initiated events resulting in death) Last	C. Due to (or	as a consequence	of):	~	11					
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dicail		a Cov	men	cution	Q1050	<i>چ گ</i>					
9	tificat ig ph) as th	ledi			$\triangle$	()					-		
Box	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnanc h 2 Fetal death	3 □Ectopic pregnan	CV				1		
	ne deat the att hed for	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		it at time of death	5 Other (specify)			Mor	nth [	Jay Ye	ear	
P.0	that the death ed by the atte detached for	Phy	9 Unknown										
Ś	signed b	by	Part II. Other significant condition	ns contributing to deal	th but not resulting i	n the underlying cause g	iven in Part I.		1			1	
ord	w requir been si should	ted	that so con					1 🗆 Ye	s 2 No	3   P100a	Oly 4Or	IKHOWH	
of Vital Record	The law requires that the ste has been signed by th bage 2 should be detache	Completed	ling co	,runam	<u></u>			24a. Was a autops	v p	rior to com	sy findings a pletion of ca	vailable use of	
E E	cete	S	X					perform 1 Yes 2	No 1	Yes 2	2□ No		
VII.	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:			thor	th (Check only on	е)				
ot	Phys this ral dir	- To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Linp	atient 2 ER/Ou	Thattent 3 DOX	ther: 4 Nursing H	ome 3 Reside					
on	ding h. After fune	ţi	Vatural 5 ☐ Pendin		Day Year)	njury W	ork? ☐Yes 2☐No	Edd. Doddilloo iid	or injury occur.	00			
Division	Attending in death.	fica	3 Suicide 6 Could r	not be 380 Place of	Injury - At home, fa	ırm, street, factory, office		28f. Location (St.	reet and Numbe	er or Rural	Route Numb	DOT.	
<u>S</u>	after after Direct	Certification:	4 Homicide	building	, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town	n, State)				
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificete has 'completely filled in by the funeral director, page 2		29a. Certifier 1 Certifyin	g Physician: To the b	est of my knowledge	e, death occurred at the	time, date and place	and due to the ca	ause(s) and ma	nner as sta	ited.		
	n 24 n n 24 n ne Fu	edicai	(Check only 2 Medical one)	Examiner: On the bas and manne	is of examination ar	d/or investigation, in my	opinion, death occur	rred at the time, da	ate and place, a	and due to	the cause(s)		
	To the within 2 To the complet	Σ	29b. Signature and title St certifier	1		29c. Licer	nse number	2	9d. Date signed	(Month, D	ay, Year)		
)	100		Let)	m)		Do	18257		8-12	-05	d <sub>a</sub>		
	110		30. Name and address of person	who completed cause	death (Item 23a)	(Type, Print)	1 6 1	1 6		01.	10.	1 .GC	
	1.		Jock	31 mon	MI	13111 (	eastel t	try C	CEGA	161	M))2	-1846	
	Sta		31. Date filed (Month, Day, Year)	100	istrar's Signature	Angell .		J	-				
	Regist	rar	AUG 1	4 LUUD A	rever S.	15 Marie							

			for AMEND#28a per PH state Registrar AACO HEALTH D	y. State of Maryla EPART. 8/16/06 CM	na / Depa H <i>Cei</i>	artment of H rtificate of L	ealth and M D <i>eath</i>	ientai Hyg	glene 200 (	5 27   3							
	Physici		1. Decedent's Name (First, Middle, La.  ALTA  L.	Fox				2. Date of Dea Month August	Day Yes 10, 2006	3. Time of Death 11:55 A M							
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. County of De								
	LAGITIII	C1	Mariner Health	of Glen Burni	2	Glen Burnie			Anne Ar	Arunde1							
	Funeral Director		5. Social Security Number 6. S 579-20-8078		. last birthday)		_	8. Date of Birt (Month, Day Sept. 14	h v, Year) 9. E	Birthplace (State or Foreign Country) irginia							
	fand ow	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits							
	a-f sh	ctor	MD Prince Georges Seabrook							1 XYes 2 □ No							
	or 28	Director	10e. Street and Number	_		10f. Zip Code			10g. Citizen of What	Country?							
	s 23e		9910 Santa Cruz	Street  12. Was Decedent Ever in	18 13 1	20706		ecify Ves or No-	USA	merican Indian,							
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "naturel; or items 23s or 28s-f show or other freumatic event, the Madical Eracial serment be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐XNo	Specify:	Rican, etc.)	Black, W	hite, etc.							
Maryland 21215-0036	thin 72 ho e. an "natur Medical	Completed	15. Decedent's E (Specify only highest grade) Elementary/Secondary (0-12)	College (1-4or 5+)		cedent's Usual Occupation we kind of work done during most of work b. DO NOT use retired)		ing	16b. Kind of Busine	iness/Industry							
2	filed wi Hyglen Sther th		12 17. Father's Name (First, Middle, Last	)	Switc	hboard Op		e (First Middle	Walter Re	ed Hospital							
anc	d be fi	o Be	William Henry J					Adena Br									
ary.	should be and Mental s marked o umatic eve	ပ	19a. Informant's Name/Relationship (		19b. Mailir	ng Address (Street a			er, City or Town, State	a, Zip Code)							
	and 2 laith a 27 is er tree		Carolyn Fox/ Dau						Leonard,								
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tre	1	20a. Method of Disposition  1 ☐ Burial 2X☐ Cremation 3 ☐  1 ☐ Donation 5 ☐ Other (Special	Removal from State	cemetery, crei	osition (Name of matory or other place ematory		2006	Waldorf,								
Balt	permit. Departr Importe any inju		21. Signature of Euneral Service	1	1	6000 Anna	polis Roa	ad Bowi	Evans Fun Le, MD 207								
	Physician /Medical Examiner	Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.	quence of):	LA OF	= Lui	~3		Interval Between Onset and Death							
Box 68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit		by Physician/M	by Physician/M	by Physician/M	by Physician/M	by Physician/M	by Physician/M		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 10	Due to (or as a consect of the description of the d	nancy tal death 3[	Ectopic pregnancy			23d. Date of Month	delivery Day Year
ds, P.O.	Se US								a rath. Differ algument contains continuing to down bachet resonant in the discontinuing of the						23e. Did tobacco use contribute to the cause of dea		
Division of Vital Record												24a. Was autop perfo 1 🗆 Yes	rmed? prior death	autopsy findings available to completion of cause of ? es 2 \( \text{No} \)			
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		_ Oth	26. Place of Deat										
on of	iding Phys th. After this funeral di	tion; To	1 Yes 2 YNo  27. Mannes of Death 1 Yatural 5 Pending 2 Accident investigation	28a. Date of Injury  (Month, Day Year)  28b. Time of Injury  28c. Injury at Work?  28d. Describe how injury occurred													
Divisi	To the Hospitel or Attending Physicien: within 24 hours effer death. To the Funerel Director: Affer this certific completely filled in by the funeral director.	Certification;	2 Accident Suicide 6 Could not be determined 6 Homicide 7 Homicide 7 Homicide 8 Homicide														
	the Hospitei hin 24 hours e the Funerel I npietely filled	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best of my k miner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	vestigation, in my o	pinion, death occur	red at the time,	date and place, and c	due to the cause(s)							
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Jutter	7	29c. License	3 \( \frac{3}{3} \)		29d. Date signed (Mo	onth, Day, Year)							
	10		30. Name and address of person who		2766	Print) 39	27 An	WAROU	is do	~06 ~5 21227							
	Sta Regist		31. Date filed (Month, Day, YAUG	1 1 2005 Registrar Sig	nature	Sports	,										

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** а м ĬŎ 2006 Lorena Figueroa August 4:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Anne Arundel Medical Center Hospice Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Under 12 1973 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 200E 33 El Salvador Director 271-86-3054 Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other then "naturel", or items 23a or 28a-f ehow 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location d other then "naturel", or items 23a or 28a-f ebovevent, the Modical Examinar must be notified at 1 ☐ Yes XX No MD Annapolis Anne Arundel Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code El Salvador 101 2nd Street 21401 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 Married El Salvador Baltimore, Maryland 21215-0036 Yes 2 No Specify: Specify. White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student University permit. Pages 1 and 2 should be file Deportment of Health and Mental Hy, Important: If item 27 Is marked other eny injury or other traumatic event, QRGS. 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Amanda Portillo Jose M. Figueroa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 101 2nd Street, Annapolis, MD 21401 Jose M. Guzman (Fiance) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8-14-2006 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Metro Crematory 21. Signature of Funeral Service Licensee Name and Address of Facility Hardesty Funeral Home, P.A. 0 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part : Enter the disease, or complications that caused its shock, or heart failure. List only one cause on each line ediate Cause (Final see or condition in death) angusarcoma Rt Best Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the th 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificete 1 ☐ Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 N Inpatient ٩ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ilis completely filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation 1 Tes 2 No death. М 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \( \text{Homicide} \) within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time date and place and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 25s Cartifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 wto completed cause of death (Item 23a) (Type, Print) w 445 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / State Of Maryland / State Of Maryland / PS,McCo	-		f Health ai of Death	nd Me			2006	27133										
	Physici		Decedent's Name (First, Middle, Last)     Sybil FAINBERG					Date of Dea Month UGUST		2006 <sup>Year</sup>	3. Time of Death 7:00A M										
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4000 Virgilia St.	4b. City, Town, or Location of Death Chevy Chase				4c County of Death Montgomery													
Ī	Funeral Director		5. Social Security Number 356-24-8935 6. Sex 1 □ M 2  F 7. Age (In yrs. last 74	birthday) Yrs.	If Under 1 Ye Months Da	ear If Under 24 lys Hours	B.Aim	Date of Birth (Month, Day eb. 14	, Year) 19	9. Birthpl Coun 111 ir	ace (State or Foreign try) 10 1 S										
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Lor	ation					10	Od. Inside City Limits										
	within 72 hours after death with the Maryland ene. than "neturel", or iteme 23e or 28e-f ehow the Madical Exeminer must be notified at	tor	Maryland Montgomery Che	vy Ch	nase						X□Yes 2□No										
	or 28	lrec	10e. Street and Number	· <b>J</b>	10f. Zip Cod	de			10g. Citiz	en of What Coun	try?										
	23a ust b	ie.	4000 Virgilia St.		208	15			Unit	ed State	es										
	teme	Funerai Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent Yes, specify (	of Hispanic Origi Cuban, Mexican,	in? (Specif Puerto Ric	fy Yes or No- can, etc.)	1	<ol> <li>Race - America</li> <li>Black, White, 6</li> </ol>											
36	urs afte	by F	1 □ Never Married	1	□ Yes <b>≱</b> (⊐	No Specify:				Specify: Wh	ite										
200	72 hou	ted	15. Decedent's Education (Specify only highest grade completed)	6a. Deced	ent's Usual Oc	cupation one during most of	of working		16b. Kin	d of Business/Inc	dustry										
2	ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	O NOT use re	tired)	or working		D	بيموط ما المارية											
2	Hygie Hygie ther t	C	17. Father's Name (First, Middle, Last)	50C1a	al Work		s Name //	First, Middle.		chiatry											
land	fental I fental I rked o	To Be	Sam Fishman				,			Shapiro											
Mary	nd 2 shoulth and N 27 is ma					a St., (				Town, State, Zip 20815	Code)										
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or Iteme 23a or 28a-1 ehow any injury or other traumatic event, the Madical Examinar must be notified at once.		1 Deurial OV Comption 3 Departural from State Come	etery, crem p <b>o1i</b> 1	sition (Name o natory or other tan Cre	matory /	Dat Aug.1	0,2006	Ale	exandria	, VA										
Balti	permit. Departm Importal any inju		21. Sign Illus of Funeral Service Licensee	25. 25.	Name and Ad	ddress of Facility	Torc N.W.	hinsky , Wash	Heb ingt	rew Function,D.C.	eral Home 20012										
	Physician	9 19	23a. Part 1. Enter the disease, or complications that caused the death. Eshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Metastatic Ma			, -	ardiac or r	espiratory arr	est,	2	Approximate Interval Between Onset and Death MONTHS										
	/Medical Examiner		resulting in death)  Due to (or as a consequence)	_																	
	ted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ce of):																	
,0928	cate be executed physicien and s the burial-transit		that initiated events resulting in death) Last C Due to (or as a consequence	e of):		-					-										
687	tificate ng phys as the	edic	σ.																		
O. Box	death cer e attendir ed for use		۵							ysician/M	ysician/M	ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deadle 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 🗌	Ectopic pregna Other (specify				2:	3d. Date of delive Month	ry Day Year
ds, P.	S C 0									Part II. Other significant conditions contributing to death but not resulting	g in the un					_	coo use contribute to the cause of death?				
Vital Record	elaw hasb je2st	Completed					_	24a. Was a autops perfor	sy męd?	prior to con death?	osy findings available npletion of cause of										
ta	ician: Th certificate ector, pag	a)	25. Was case referred to medical			26 Place o	of Death (*	1 ☐ Yes Check only or	2XI No	1 🗆 Yes	2   No										
<b>*</b>	9 v =	To B	examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient	3□ DOA	Other				☐Other (Specify	)										
Division of	ding h. Aftei fune		27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	b. Time of Injury		njury at Work? 1 □ Yes 2 □ N	y at 28d		28d. Describe how injury occurred												
Divis	al or Attenos s after deatl al Director: ad in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	farm, stre	et, factory, off	ice	281	Location (S City or Town	treet and n, State)	Number or Rurai	Route Number,										
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edicai (	29a Cartifier (Check ont) 2 Medical Examiner: On the basis of examination and manner stated.	ige, death and/or inv	estigation, in r	e time, date and ny opinion, death	place, and occurred	due to the e at the time, d	auca(c) t late and p	and manner ac et place, and due to	the cause(s)										
	To the within 2 To the complete	W	29b. Signature and title of certifier		29c. Lic D335	sense number 554		2	9d. Date	signed (Month, L	Day, Year)										
	5		30. Name and address of person the commetted druse of death (Item 23 John Yerg, 5410 Conn. Ave., N.W.	a) (Type, F Was	<sub>rint)</sub> hinator	n. D.C.	2001	5			-										
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 1 2006  32 Registrar's Signature	So	relie																

State of Maryland / Department of Health and Mental Hygien 2006 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Aug 22, 2006 Year **Physician** 0227 Hansrote Evelyn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany Cumberland Allegany County Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 5, 1913 Birthplace (State or Foreign
 Duntry) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2√2 F Director 93 Yrs. 219-46-0127 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examinar must be notified at Cumberland Allegany MD 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA "natural", or Items 23a 21502 13213 Cresap Street permit. Pages 1 and 2 should be filled within 72 hours atter death a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a any injury or other traumatic and the statements. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes Z No Specify:white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia E. (Beckman) Mason Charles C. Mason 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21502 12034 Kite Avenue SW Cumberland daughter Willa Engle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/24/2006 MD Sunset Memorial Park Cumberland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral ervice Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WOSEDSIS **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or): Examiner The law requires that the death certificate be executed attending physician and tor use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No by the 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 TYes 2 \( \text{No.} or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Atter 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 - Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of opnifier 1 Lan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Furnace Street Ext. Cumberland MD 21502 32 Registrar's Signate State Registrar

State of Maryland / Department of Health and Mental Hygien 2006 27136 1 - For Stete Registra Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 12,2006 7:40A M MANDY HUGHES JANE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner GENESIS LA PLATA CENTER CHARLES LA PLATA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT - 17,1911 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Months Days Hours MISSISSIPPI Yrs. Director 587-84-9892 94 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Madical Exprision must be notified at XYes 2 No Director MARYLAND CHARLES LA PLATA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral #1 MAGNOLIA DRIVE 20646 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes XINo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after used Mental Hygiene.
Is marked other than "natural", or Iter XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CHARLES HUGHES CARRIE BOOSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: ff itam 27 ia m any injury or other traum 5916 MICHAEL RD., WALDORF, MARYLAND 20601 VIRGIE M. NICHOLS-NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 8-18-06 CLINTON, MARYLAND 21. Signature of Funeral Service Licensee MOO 2. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HRON **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** POLY CYSTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed the burial-transit Due to (or as a consequence of): Box 68760. Physiclan/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten 2 Fetal death in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à HEAM 1 Yes 2 No 3 Probably 4 Manknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death 28h Time of 28d. Describe how injury occurred al or Attending F s after death. After 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.
To the Funerel Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D. 44436 Aaw 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) ASHVINKUMAR JPATEL 102 PAYLMENON CT WALDORFMD 20602 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

ed #1		1- For per M.D., T		06,sbb C	ertificat	e of E	Peath		Heg. No.	200	6	27/38	
Physici /Medic		1. Decedent's Name (First, Middle ROBERT	E E	•	HAWK	H	auk	2. Date of D Aug.		2008	Year O	3. Time of Death 09:12 ам	
Examin	er	4a. Facility Name (If not institution Univ. of Man	yland Me		t Ba	ltim				County of	Death		
uneral irector		5. Social Security Number 220–22–2472	6. Sex 7. 1 X M 2 □ F	Age (In yrs. last birthd 78 Yrs	Months		Hours M		11,1	928	9. Birthp Cour Mary	place (State or Foreign http) Land	
thow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o							1	10d. Inside City Limits	
or course	Directo	MD TALBO		EASTO	10f. Zip Code 10g. Citizen of What								
event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Marr  3 Widowed 4 Divorced	12. Was Decede Armed Force	<b>∑</b> No		dent of His cify Cuban	panic Origin? , Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Black,	Amend White,	etc.	
s Medical	mpleted	15. Deceden (Specify only higher Elementary/Secondary (0-12)	's Education it grade completed) College (1-4	or 5+)	ecedent's Usu live kind of wo e. DO NOT u	se retired)	ion uring most of w	vorking					
	To Be Co	17. Father's Name (First, Middle, John Edward Ha	Last)		оу рет v 1			ame (First, Middle es Mechli	e, Maiden			CITE	
other traumatic	_	19a. Informant's Name/Relations David E. Hauk/								g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc. Specify. White  6b. Kind of Business/Industry  S. Government aiden Sumame) 6ki  City or Town, State, Zip Code) MD 21228  0c. Location - City or Town, State aston, Maryland  Funeral Home, P.A.  Approximate Interval Between Onset and Death  23d. Date of delivery Month Day Year  24b. Were autopsy findings availab prior to completion of cause of death? No  24b. Were autopsy findings availab prior to completion of cause of death? No  1 Yes 2 No			
ury or othe		20a. Method of Disposition  XXBurial 2 Cremation  4 Donation 5 Other (S)		20b. Place of Di WoodTawi	sposition (Nai crematory or c n Memoi	me of ther place	Pk   8/1	Date 6/2006	20c. Location - City or Town, State Easton, Maryland				
any injury or ot once.		21. Signature of Funeral Service	Off whi	L.F.5.0	22. Name ar Fe11ows 200. S.	s,Hel:	fenbeir	n & Newna St East	m Fu	neral Marvl	l Ho	me, P.A. 21601	
sician edical miner	niner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Coron Due to (or	ary Arter as a consequence of): as a consequence of):	cy Dis							Interval Between	
the burial-transit	edicai Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):									
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ec de	by	Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I.											
page 2 should I	Completed				24a. Wa auto peri 1 \( \triangle Yes	ppsy prior to completion of cause of death?							
24 hours after death.  • Funerel Director: After this certificate letely filled in by the funeral director, pag	tion: To Be	25. Was case referred to medical examiner?  1  Yes  2 X No  27. Manner of Death  1 X Natural  5  Pendin investig	9	njury 28b. Tim	Other			Home 5 Res	th (Check only one) ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			у)	
	Certification:	3 Suicide 6 Could determ	Injury - At home, farm, , etc. (Specify)	street, factor	y, office		28f. Location City or To	(Street and own, State,	d Number )	or Rura	l Route Number,		
completely fills	edical C	29a. Certifier (Check only one)  Certifyin  2 Medical	g Physicien: To the be Examiner: On the base and manner	s of examination and/o	eath occurred r investigation	at the time	, date and pla nion, death oc	ce, and due to the curred at the time	cause(s) , date and	and mann place, and	ner as st d due to	tated. the cause(s)	
duoo	Me	29b. Signature and title of certifie	ND			L 7433				e signed (		Day, Year)	
Sta	te	30. Name and address of person  Dr. Joanna B  31. Date filed (Month, Day, Year)  SEP 11 2	ock, 22 S			et, E	Baltim	ore, Mo	212	201			

State of Maryland / Department of Health and Mental Hygiene 20061 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** August 13, 2243 Gary Wilbur Hipkins 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**X** M 2 □ F 212-32-2625 Yrs. Director 71 21, 1934 Dec. Maryland Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits Show "natural", or items 23s or 28s-f shovedical Examiner must be notified at 1 ☐ Yes 2 No Maryland Cecil Conowingo Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 699 Conowingo Road 21918 U.S.A. should be fited within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed other than "natur 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Gichner Shelter Systems Elementary/Secondary (0-12) College (1-4or 5+) Twelve Years Manufacturing Engineer Dallastown, Pennsylvania 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wilbur Hipkins Marian Robinson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avanell Hipkins (wife) itam 27 699 Conowingo Road, Conowingo, Maryland 21918 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ₺ Burial 2 □ Cremation 3 □ Removal from State St. Mark's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 08/18/06 Perryville, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Thomas Ottom Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Circulator /Medical Due to (or as a consequence & Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9□ Unknown 9 🗆 Unknown s been signed by I should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an renal perform certificate 1 Yes 2 No 1 ☐ Yes Attending Physician: : After this certification, 25. Was case referred to medical Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No patient 2 ER/Outpatient 3 DOA of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending death. investigation 1 Tes 2 No 2 Accident within 24 hours after death To the Funaral Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide o the Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of ceriffier 29c. License number 29d. Date signed (Month, Day, Year) 121338 AUGUST. 14. 2006 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALANSWEATTHAN HANFORD METTORIAL HOSAITAL, HAUNO OR GRACE AUG 1 5 32. Registrar's Signature 31. Date filed (Month, State 2006 Slower St. Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6

Amend Item 17 per FH, G859, 09/28 / 06 bb Amend Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Jennie Mary Harrington August 12:45 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Denton
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Caroline Nursing Home, Inc. Caroline Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 F Months Yrs. 95 218-72-5185 October 6, 1910 Director Marylana Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Expressment be notified at 1 ☐ Yes 2 ☐ No Director Maryland Caroline Ridgely 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12705 Hog LotRoad 21660 United States of America Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Emanuel Biser Emanuel 2 Savilla Secrist other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau 12705 Hog Lot Road, Ridgely, Maryland 21660

Date 20c. Location - City or Town, State David S. Harrington Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 € Burial 2 Cremation 3 Removal from State Fairview Church Cemetery 8/16/2006 ' 4 ☐ Donation 5 ☐ Other (Specify) Cordova, Maryland 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Immediate Cause (Final disease or condition resulting in death) years Physician ena estive /Medical Due to (or as a consequence of) **Examiner** squarticly life could not any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed use as the burial-transit Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 Yes 2 🕅 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 Yes 2 No of Vital ospitel or Attending Physicisn: 1 hours after death. uneral Director: After this certifical y filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Medical Certification: Division 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)0047534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 920 Market Street, Denton, Maryland 21629 Walik Zaki, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 20061 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year Einer 4:44 PM Johnson, Sr. 8 0 08 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. Min. A. Date of Birth (Month, Day, Year)

Apr. 21, 1 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**反**M 2□F 74 Director 064-24-9411 Yrs. NY Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location other then "netural", or items 23a or 28a-f ehow vent, the Madical Examiner must be notified at 10d. Inside City Limits MD Anne Arundel Director Severna Park 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Benfield Road 21146 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Black, White, etc. 1 XYes 2 No
If Yes, Give
Year or Dates: Korea 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify. 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coltege (1-4or 5+) Elementary/Secondary (0-12) Chief of Staff MD Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Einer James Johnson Laura Fitzsimmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Melissa J. Mullady/Daughter 101 Summersrun, Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of himportant: If ite eny injury or of page. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Aug. 10 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 2006 21. Signature of Feneral Service Licensee Rarranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner acute Sequentially list conditions, it any, reading to immodiate cause. Enter Underlying Cause (Disease or injury that inflated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical use as for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death signed by the a d be detached to 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificete has t lirector, page 2 s autopsy performed? 1 ☐ Yes 2 110 Division of Vital After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 (Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 GNatural 5 Pending death. investigation 1 TYes 2 No Director: / 2 TAccident 6 ☐ Could not be within 24 hours after d.

To the Funerel Director completely filled in hem. 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060721 M.D. 08,08, (Columb 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rolurado Falcon, M.D. 301 Hospital Drive, Glen Burnie, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 1 ZUUD Registrar

JOHNSON

State of Maryland / Department of Health and Mental Hygiena 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month DAVID WILLIAM KEHRER AUGUST 18, 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9779 EMERALD STREET NEWBURG CHARLES If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) Days Hours 1MM 2□ F Director 371-44-4940 63 Yrs. JUNE 1,1943 MICHIGAN Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits show itam 27 is marked other than "natural", or Itams 23a or 28a-f shov other traumatic evant, it e Madeal Examiner over be notified at 1 Yes 2 100 Directo MARYLAND CHARLES NEWBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9779 EMERALD STREET 20664 death Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? \(\times\) \(\times\ Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 in and Mental Hygiene.
7 is marked othar than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 BUILDER?GEN.CONTRACTOR TDM HOME IMPROVMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIAM FRANCIS KEHRER LILLIAN JANE AUSTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is n any injury or other traun once. SHARON KEHRER-SPOUSE 9779 EMERALD STREET, NEWBURG, MD 20664 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial XXCremation 3 ☐ Removal from State
`4 ☐ Donation 5 ☐ Other (Specify) M E METROPOLITIAN CREMATORY 8-21-06 ALEXANIRIA, VA 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. Do not enter the mode of dying, such MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MMedilett disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 2 D No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No Division of Vital 1 Yes 1 TYes Be 25. Was case referred to medical 26. Place of Death (Check only examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 Yes 4 🗆 Nursing Home Residence 6 Other (Specify) the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Hospital or Attending P
 24 hours after death.
 Funaral Diractor: After t Certification: Injury Natural 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funaral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mappine/ stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of perspo completed cause of death (from 23a) (Type, Print) 31. Date filed (Month, Day, Year, Registrar's Signature State AUG 2 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygieney

27143 For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** BARBARA POPE KIRBY AUG. 2006 2:30 A /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT HOSPICE HOUSE **EASTON** TALBOT If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months DEC. 12,1927 Director 213-22-6238 78 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director EASTON MD TALBOT 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code or items 23a 8955 BLACK DOG ALLEY 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 b 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 XWidowed 4 ☐ Divorced Year or Dates: "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, It a Ms College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LESLIE A. POPE ELIZABETH STARR ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK KIRBY/ SON 15023 CHERRY LANE, RIDGELY, MARYLAND 21660 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State MARYLAND VETERAN \* 4 ☐ Donation 5 ☐ Other (Specify) 8-11-2006 HURLOCK, MARYLAND CEMETERY 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. C.F.S.R Joseph m. Ostroush' 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) can ce **Physician** /Medical Failure Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of Examiner The law requires that the death certificate be executed burial-transit Wension and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy į in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Dementro 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has page 2 лπed? 2**ΩN**ο certificate 1 Yes Division of Vital the Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 HOSPICE HOUSE 1 ☐ Yes No ဥ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direct 4 Homicide E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical pletely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0057821 D 0. 30. Name and address of person of completed cause of death (Item 23a) (Type, Print) Valeric Crowd Compan D.O. 2540 Centruille Rd, Centruille MD 21617 31. Date filed (Month, Day, Year)
AUG 0 8 2005 Aegistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 2006 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** August 8,2006 6:00pm Dora Jean McKee Korner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner #N608 8101 Connecticut Ave, Chevy Chase Montgomery If Under 1 Year | ff Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Ju 1922 217-48-9571 1 ☐ M 2 🗓 F 84 Mexitob Director Usual Residence of Decedent death with the Maryland work 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylar Depertment of Health and Mental Hygiene Importent: if item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinational to nutified at once. Chevy Chase 1X Yes 2 ☐ No Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #N608 20815 United States 8101 Connecticut Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Findley McKee Mary Louise Ramsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jules Korner /Son 19217 Plummer Dr., Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place)
Church Cemetery
Kernersville Moravian 8-17-06 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Kernersville, NC 21. Signature of Funeral Service/Licenses 22. Name and Address of Facility Joseph Gawler's Sons, INc 5130 Wisconsin Ave, N.W. Washington DC 20016 4 unay 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Priysician Advanced Parkinson's Years /Medical Due to (or as a consequence of): Examiner Pneumonia One Month Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien and tor use as the burial-transit The law requires that the death certificate be executed Biliary Cirrhosis Years Due to (or as a consequence of): Box 68760 Physician/Medical d IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 X No Hospitel or Attending Physicien: 24 hours after death. Funerel Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Yes 2 ▼ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 28c. injury at Work? Certification: 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accider fnjury 5 Pending 1 ☐ Yes 2 ☐ No Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide pelili 24 hours a 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD 33485 August 9,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Thomas M. Loughney, M.D. 3301 New Mexico Ave, N.W. Washington DC 20016

31. Date filed (Month, Day, Year)

**AUG 1 1** 2006



State

Registrar

			1 - For Stete Registrar	State of Ma	aryland / De	partment <i>ertificate</i>			lental Hyg	giene Reg. No. 2 (	006	27145
	Physici /Medie		1. Decedent's Name (First, Middle, La Leonard L.		einberg.				2. Date of Dea Month August	ath		3. Time of Death
	Examir		4a. Facility Name (If not institution, given 23227 Hickory Nut			Cali	forn				ity of Death Mary	's
	Funeral Director		077-20-2816	Sex 7. Agr 1 ☑ M 2 ☐ F	e (In yrs. last birtho 78 Yrs	Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day May 3,	1928	9. Birthp Cour New	place (State or Foreign http) York
	a-f show	ctor	Usual Residence of Decedent  10a. State  10b. County  Maryland  St. Max	ry's	10c. City, Town o						1	0d. Inside City Limits 1X Yes 2 □ No
	oth with the 23s or 28 ust be not	ai Director	10e. Street and Number 23227 Hickory Nu	t Drive		10f. Zip (	Code 1619			10g. Citizen o	S • A •	•
980	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hyglene. Important: if tem 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 🖾 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ZYes 2 1 If Yes, Give Year or Dates:		3. Was Decede If Yes, speci 1 ☐ Yes 2	ify Cubai	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ra Bi	ace - Americ lack, White, eify:	
Maryland 21215-0036	within 72 ho iene. • then "natur ine Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0·12)		i+) (G	ecedent's Usual live kind of work e. DO NOT use Ctronic	k doné d e retired,	uring most of worki )	ing	16b. Kind of	Business/In	
land 2	uld be filed Mental Hygi irked other itic event, I	To Be Co	17. Father's Name (First, Middle, Last Harry Kleinber	)				18. Mother's Name	(First, Middle, ude Bes	Maiden Suma		
, Mary	and 2 sho lealth and ! m 27 is ma		19a. Informant's Name/Relationship Neil A. Kleinber		271	0 Crest	viev	nd Number or Rura  ▼ Road, R	iva, Ma	ryland	21140	)
Baltimore,	t. Pages 1 rtment of H rtant: If ite		20a. Method of Disposition  1 🛱 Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special Control of Control	(y)	Judean	Mem. Go	her place ins	8/11/			y, Man	ryland
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Company	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or comshook, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, is any, leading to immediate	a. Due to (or as	espirator a consequence of): ongestive a consequence of):	y Failu	ıre		in respiratory arr	est,		Approximate Interval Between Onset and Death
38760,	icate be executed physician and s the burial-transit	edicai Examin	is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	ardiomyop a consequence of):	athy						
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pre 5 □ Other ( <i>spe</i>					ate of delive	ory Day Year
ords, P.	The law requires that ite has been signed b age 2 should be dete	þ	Part II. Other significant conditions $C \bullet O \bullet P \bullet D \bullet$	contributing to death bi	ut not resulting in th	e underlying ca	use give	n in Part I.		bacco use coi es 2 □ No		ably 4 X Unknown
Vital Records,	n: The law i licete has b r. page 2 st	Completed								sy med? 2 💢 No	. Were autoprior to condeath? 1 Yes	psy findings available inpletion of cause of
of Vit	iding Physicien: ] th. : After this certificel stuneral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No		nt 2 ☐ ER/Outpa			4   Nursing nor	ne 5Ă Resid	ence 6 🗆 Ot		()
Division of	to the	Certification:	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  5 Pending investigation 6 Could not be determined	On Dinn of Init	Year) Inju	М		es 2 □No	28d. Describe hi 28f. Location (S. City or Town	treet and Nun		l Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edicai Ce	29a. Certifier 1 ☑ Certifying Pl (Check only one) 2 ☐ Medical Exa	nysician: To the best of miner: On the basis of and manner sta	of my knowledge, d examination and/o	eath occurred a	it the tim	e, date and place, a	and due to the c	ause(s) and n late and place	nanner as st	ated. the cause(s)
)		Me	29b. Signature and tile of certifier	Park	EM	29c.	License	number 06419	2	9d. Date sign	ed (Month,	Day, Year)
10	)+1		30. Name and address of person who Dr. James P. Ja	. //	eath (Item 23a) (Ty 5 Three N	,	ad,	Hollywoo	d, Mary	land 2	20636	<u> </u>
	Sta Registr		31. Date filed (Month Day Year)	1/ 20 Dh-inter	ar's Signature	Soule						

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JACQUELYN 08 1:25 LEE KEASER 14 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2148 Worcester Hwy., Lot #6 Pocomoke City Worcester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □XF 66 Yrs. Director 219-36-6662 Maryland 6/14/1940 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Itame 23a or 28e-f ehow The Medical Examinar must be notified at 1 Yes 2 No Directo Pocomoke City Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2148 Worcester Hwy., Lot #6 21851 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ited within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Itimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked of Russell Howard Frances Maddox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health Michael I. Keaser (husband) 2148 Worcester Hwy., Lot #6, Pocomoke, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 8/17/2006 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Beth Eden Tilohman Hill Cemetery Pocomoke City, MD 22. Name and Address of Facility
Holloway Funeral Home, P.A. 21. Signature of Fungral Service Licensee Run 103 Linden Avenue, Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Cancer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 ☐ Probably 4 ☐ Unknown Completed Yes 2 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate hes t irector, page 2 s 1 Tes 1 ☐ Yes of Vital After this certification, i Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) No No 1 Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Director: / 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ŏ To the Hospitel within 24 hours a To the Funarel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Sienature and title of c 29d. Date signed (Month, Day, Year) 026278 1- Box 1733 seister 6A 5 egistrar's Signature 31. Date filed (Month, Day, Year) 32. State AUG 1 5 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 8 per Th 8858 8-28-06 vt. State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Kenneth Month Laughman 4154 AM Augus 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hopkins Hospital Baltimore Baltimore Johns 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day, Ye Birthplace (State or Foreign Country) Days Hours Months Min. 172-40-8388 52 Yrs. Aug. 8, 1954 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits York 1 ☐ Yes 2 ☑ No Manchester 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 93 Conewago Avenue 17345 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 12 Assembler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert W. Laughman Anna Bell Woodring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert W. Laughman/Brother 3471 Schoolhouse Rd., Dover, PA 17345 20b. Place of Disposition (Name of competery, crematory or other place)
Yorktowne
Cremation Service 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 X Removal from State 22, Aug. 2006 4 □ Donation 5 □ Other (Specify) York, PA 17404 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 2/ Men Mile 24 Second St., New Freedom, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lischemic bowe 12 hours Due to (or as a consequence of): days neumonia Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 № No 24a. Was an 1 ☐ Yes 2 No 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ★Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

**Physician** /Medical the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the been signed by t should be detach certificete has b director this After thi death. Director: , within 24 hours after To the Funeral Direct Pelli

Physician

/Medical

Examiner

10a. State

PA

**Funeral** 

Director

in than "natural", or Iteme 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filled v Department of Health and Mental Hygies Importent: If Item 27 is marked other tt any Injury or other treumatic event, the once.

Funeral Director

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Completed

Be

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. C4:::pieted Be 25. Was case referred to medical examiner? Medical Certification: To 1 ☐ Yes 2 🔀 No 27. Manner of Death 1 Natural
2 Accident 3 ☐ Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number Resident

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Parana

31. Date filed (Month. Gay

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Res-000

Wolfe Street Baltimore, MD 21287-4106

State

Registrar

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State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Lee Long Edward 2006 2:45 PM August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Federalsburg Caroline Grove Road #3D 3460 Laurel 7. Age (In yrs. last birthday)
60 Yrs.

| Months | Days | Hours | Min. | Jan. 27, | Jan. 27, | 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1**⅓**M 2□ F 1946 North Carolina Director 220-42-1165 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or iteme 23a or 28a-f show the Medical Examinar must be notified at Federalsburg 1 TXYes 2 □ No Caroline Director MD10g. Citizen of What Country?
United States 10e. Street and Number 10f Zin Code 21632 3460 Laurel Grove Road # death Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White <u>۾</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked othe any lighty or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Magdalene Edwards Long Thomas Harvey Lee Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 416 Hickory Lane, Seaford, DE 19973 19a, Informant's Name/Relationship (Type, Print) Melissa Michaud/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bloomery Cemetery 08/16/06 Federalsburg, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, Esken Michael 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal failure **Physician** /Medical Due to (or as a consequence of): Examiner Dehydration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed diffuse histocutic I um Due to (or as a consequence of): Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed? has 1 ☐ Yes Hospital or Attending Physician: funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Salatural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death, Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053922 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 136 Lednum Ave Preston Melinda Butler MO DILSS 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 16

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

2006

		_	1 - For State Registrar	State of M	laryland		artmen <i>tificate</i>			and M		gienez Reg. No.	006	27149
	Physici	an	1. Decedent's Name (First, Middle, L	ast)							2. Date of De. Month	ath Day	Year	3. Time of Death
	/Medi		BRENDA ALFO								AUGUST	16 20	006	12:00 PM
	Examir	er	4a. Facility Name (If not institution, g		-)		,	Ť	Location o	of Death			unty of Death	
194	Funeral	9	CIVISTA MEDICAL 5. Social Security Number 6.		ge (In yrs. la	st birthdav)	LAPI If Under		If Under	24 Hrs.	8. Date of Birt		ARLES	place (State or Foreign
	Director		215-46-1468	1□ M 2/QXF	61	Yrs.	Months	Days	Hours	Min.	(Month, Da JULY	y, Year)	Cou	IRGINIA
	pu *		Usual Residence of Decedent  10a. State 10b. County		10- 07-	Ŧ					OOLI	20/13		
	Aarylar I ehow	ō			TOC. City,	, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes X☐XNo
	death with the Maryland ms 23a or 28a-f ehow Emust be notified at	Director	MARYLAND CHAR  10e. Street and Number	LES		LA P	LATA 10f. Zip	Code				10a Citizen	of What Cou	
	3a or		9580 SHARON AV	· 🗗				0646	-			rog. Omzon		
		Funeral	11. Marital Status	12. Was Decedent	t Ever in U.S	i. 13. V				gin? (Spe	cify Yes or No- Rican, etc.)	14.	U.S. A	ican Indian,
36	or Ite		1 Never Married 2 Married	1 ☐ Yes 2 X			Yes 2		Specify:	, Ривпо г	tican, etc.)		Black, White	, etc.
Ö	within 72 hours after ane. "naturel", or Ite mudicul Executor	d by	3 Widowed 4 Divorced	Year or Dates:										HITE
-5	d within 72 h jiene. r then "natu	Completed	15. Decedent's l (Specify only highest g	rade completed)		16a. Deced (Give :	lent's Usua kind of wor DO NOT us	k done di	urina most	of workin	g	16b. Kind	of Business/Ir	ndustry
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Maryland 21215-0036			19a. Informant's Name/Retationship	(Type, Print)		19b. Mailin	g Address	(Street a	nd Numbe	r or Rural	Route Numbe	r, City or To	wn, State, Zi	o Code)
	of Health of Hem 27 i	ļ	ELLSWORTH MIL	LS,JRH	USBAN	ID 9.	580	SHAF	ON I	VE.	LA PI			AD20646
יסר	O = = 0		20a. Method of Disposition 1XX urial 2 ☐ Cremation 3	☐Removal from State	Cei	ace of Dispos metery, crem	atory or of	her place	1		ite		on - City or T	
Baltimore,	nit. Pa artmer ortant: Injury	Ť	4 ☐ Donation 5 ☐ Other (Special Signature of Fugeral Service Lice								21-06	WALD	ORF,M	ARYLAND
Ba	permit. Departr Importe any Inju		21. Signature on autoral Service Lice	0	M0047		. Name and RAYM(				SERVI	ICE,	P.A.	
			23a Part1. Enter the disease, or cor	nplications that cause	d the death.									Approximate
	Physician		shock, or heart failure. List onf Immediate Cause (Final disease or condition	one cause on each I	ine.				1	1.				Interval Between Onset and Death
78	/Medical		resulting in death)	Due to (or as	a conseque	ence of):	7	in	~~					
	Examiner		Sequentially list conditions.	b	gue	white the	~ -6	ry	w/					
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):	6		. 5	1				
۸	be executed sicien and burial-transit	xan	that initiated events resulting in death) Last	C. Due to (or as	a conseque	ence of		CYI		`				
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9	tificate ig physi as the b	ledi		- U.	/									
Вох	requires that the death certific een signed by the attending p nould be detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pre	onano.				23d.	Date of delive	ery
	ne dea the att	sicia	in the past 12 months? 1 Yes 2 No	4 Pregnant a			Other (spe						Month	Day Year
P.0	that the di ed by the detached	Phy	9 ☐ Unknown  Part II. Other significant conditions	contabuting to death h	nut pat sacult	ing in the con-	at a state of a second				00 - 5:44			
Records,	signed d be del	Completed by	Brotes 10	was re	War.	emen	derlying ca	Lus	1200	lue	230. Did to			he cause of death?
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-	ician: Th	ပိ	25. Was ease referred to medical	-, asker	perso	is, c	ongel	m /	Bent 1	ache	1 Yes	2 No		2 No
Ξ	ding Physician: h. After this certific funeral director,	To Be	examiner? 1 🗌 Yes 2 🔀 No	Hospital:	ent 25 E	R/Outpatient	3□ DO/	Other			<i>Check only or</i> e 5 ☐ Reside		Other /Securit	
		- L	27. Manner of Death	28a. Date of Inju (Month, Da		8b. Time of		c. Injury			d. Describe h			y)
Sio	Attending r death.	Certification:	1 Natural 5 Pending 2 Accident investigation	n l	, , , ,	inquiy	М		es 2 🗆 N	lo				
Ξ	or Att	Ě	3 Suicide 6 Could not l 4 Homicide determined	28e. Place of In	jury - At hom tc. <i>(Specify)</i>	e, farm, stre	et, factory,	office		28	f. Location (Si City or Town	reet and Nu n, State)	imber or Rura	I Route Number,
	pital		On Carting (Fig. 1)											
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	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Me	29b. Signature and title of certifier	and manner st	atou.			License					ned (Month,	
	- s + ô		1 Bandi	Likell	The	11)		-0008						2006
	Ó	}	30. Name and address of person who	completed cause of c	death (Item 2	(Type, F			,570				, , , ,	~ `×'
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	Sta Registr	e	31. Date filed (Mariting Pain Year)	1.706	ar's Signatu		-	~~A	±	LAI L	arta l'IV	<del>~~200</del> 4	<del>\</del>	

			For State Registrar		State of Ma	arylan	d / Depa <i>Cei</i>	artment tificate	of H	ealth a	ınd M		giene2	006	27150	)
	· Physici	an	1. Decedent's Name	(First, Middle, L	0							2. Date of De Month	Day	Year	3. Time of Death	1
,	/Medic Examin				ive street and number)			4b. City, T	own, or	Location o	f Death	Muzusi		ounty of Dea		-
	LAGIIII		UNIVERSIT	YOF M	ARYLAND M	ED C	ENTER	E	BAL	TIMO						
	Funeral Director		5. Social Security Nu 219-01	-4728	Sex 7. Ag 1□M 2—— 7. Ag	e (In yrs. i	ast birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da April 2	h y. Yea <i>r)</i> 7 <b>,</b> 19	Co	thplace (State or Foreign ountry) Yland	7
	and		Usual Residence of 10a. State	10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits	;
	Mary Fied	ţō	MD	Harfor	d	H	avre d	e Gra	ce						to 2 □ No	,
	death with the Maryland me 23s or 28s-f show Littust Le notified at	Director	10e. Street and Num	nber				10f. Zip (	Code				10g. Citize	n of What Co	ountry?	
	23a c		606 Ma	rket St	reet				210					S.A.		
	er de	Funerai	11. Marital Status		12. Was Decedent Armed Forces?		S. 13. \	Was Decede f Yes, speci	ent of His fy Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto l	cify Yes or No Rican, etc.)	- 14	Race - Ame Black, Whit		
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and	T to the second	Be	17. Father's Name (/		rmstrong							(First, Middle,  McDona		imame)		
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altimore,	s 1 an f Heel item 2 other		20a. Method of Disp	osition		20b. P	lace of Dispo	sition (Nam	e of	- 1		ate		tion - City or		_
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_	ires the signed t be de	Ď	Part II. Other signifi	cant conditions	contributing to death b	ut not res	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did t		/	o the cause of death? robably 4 🗍 Unknown	1
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o uo	ding Pt h. After th funeral		27. Manner of Death 1 Matural 2 Accident	5 Pending investigat	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	f 28	3c. Injury Work	at ? ′es 2 ☐ f		28d. Describe I	now injury	occurred		
Division of Vital	5 g g c	Certification;	3 Suicide 4 Homicide	6 Could not determine	28e. Place of Injury	ury - At ho c. (Specif	ome, larm, str y)	reet, lactory,	, office			28t. Location (: City or Tox	Street and i vn, State)	Number or R	ural Route Number,	
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	15		30. Name and addre	ess of person wh	o completed cause of	death (Iten	n 23a) (Туре,	Print)							, 0	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Year Month Physician John Edward Manley, Jr. 2006 11:40/Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Director 210-30-5031 23. 1935 Pennsylvania Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other then "naturel", or items 23a or 28a-f ehov treumatic event, tre Medical Exempre must be notified at 1 ☐ Yes 2 🔯 No Maryland Queen Annes Chester Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. important: if item 27 is marked other then "--- any injury or other treument— any injury or other treument— 7A Queen Victoria Court 21619 United States Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1956 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ∑Yes 2 No fYes, Give rear or Dates: 1 Never Married 2 Married 1958 1 ☐ Yes 2 😾 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) President Elevator Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Edward Manley, Sr. Claire Longen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara H. Manley / Wife Queen Victoria Court Chester, Maryland 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory |8/12/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cancer two disease or condition resulting in death) 119 /Medical Due to (or as a consequence of) months Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. δ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 27. Manner of Death 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred After 5 Pending within 24 hours after death.

To the Funeral Director: A 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Fo the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Road #300 Hunyro 900 DOTGUTE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

4

32. Pogistrar's Signature

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

Ivy Nicole Mayhew 27152 2006 1. For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ August 13, 2006 1319 hrs Ivv Nicole Mayhew Medical Examiner 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 19 Beechwood Road If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign Maryland Months Davs Hours April 22, 1974 32 220-15-5962 Director 2XXF Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County Anne Arundel Arnold 1 Yes 2 XXNo Maryland 28a-f shov hours after death with the Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19 Beechwood Road 21012 U.S.A. or items 23a Funeral 12. Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 x Married 2 X No Yes White Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 hener of Health and Mental Hygiene.
aut: If item 27 is marked other than "r Manager/Trainer Restaurant MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alexander F. Parkinson, Jr. Madeleine A. Fisher æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Madeleine A. Parkinson/mother 1588 Native Dancer Court Annapolis, MD 21409 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Saltimore, crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State Department of Important: I injury or othe 8/18/2006 Hillcrest Mem. Gardens Annapolis, Maryland Donation 5 Other Specify 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral 147 Duke of Gloucester St., Annapolis, MD 21401 1 lich se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and 23a. Part I. Enter the disce **Physician** failure. List only one cause on each line /Medical Death a Strangulation Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? 2 Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown q Linknown the 23e. Did tobacco use contribute to the cause of death? gned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has page 2 performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No 26.Place of Death (Check only one) Fo the Hospital or Attending Physician: 25. Was case referred to medica Be examiner? Other<sub>4</sub> Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 DOA FR/Outpatient 3 After this 2 မ 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject strangled FOUND Natural Yes 2 V No 5 Pending within 24 hours after death. To the Funeral Director: in by the Aug 13, 2006 1310 hrs 2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined (Specify) Single Family Home 19 Beechwood Road, Arnold, MD 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 14, 2006 and address of person who completed lause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Pay 32 Registrar's Signature G 15 State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month DOROTHY J. MARKS AUGUST 9, A M 2006 6:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MAPLEWOOD PARK PLACE NURSING HOME MONTGOMERY BETHESDA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, OCTOBER 1, 19 Birthplace (State or Foreign Country)
 NEW YORK **Funeral** Days Hours Months 1 ☐ M 2 🛛 F Director 91 1914 577-09-8843 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. Hydiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits in than "natural, or Items 23s or 28s-f show the Michael Examinar must be notified at 1 X Yes 2 ☐ No MARYLAND MONTGOMERY BETHESDA Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9707 OLD GEORGETOWN ROAD 20814 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify. Completed by WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HEALTH AND HUMAN SERVICES EXECUTIVE SECRETARY 12 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H. sant: If Item 27 is marked other Be ဂ္ **JACOBS** ANNA GANSLER GEORGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5813 LONE OAK DRIVE, BETHESDA, MARYLAND 20814 ROBERT A. MARKS/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It injury or 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MT. LEBANON CEMETERY 08/11/2006 ADELPHI, MARYLAND 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC.
11800 NEW HAMPSHIKE AVENUE, SILVER SPRING, MARYLAND 20904 21. Signature of Funeral Service Licensee udeura 23a. Part1. Enter the disease, or remplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of) Examiner END STAGE DEMENTIA Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the Hospitel or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No. 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 ☐ Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 XNatural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: ţ, 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral [ 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

30. Name and address of person who completed cause of death (from 23a) (Type, Print)

emere

D35791

**ORIGINAL** 

9801 GEORGIA AVENUE, SUITE 227, SILVER SPRING, MARYLAND 20902

AUGUST 9, 2006

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006

Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Year A. Month George **Physician** August 9, 2006 ам 3:45 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 11417 Lund Place Kensington Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 16 M 2 ☐ F Yrs Director 577-12-4792 85 July 22, 1921 Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Items 23a 11417 Lund Place 20895 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1★□ Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 3€ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: β Specify: White 3 ☐ Widowed 4 ☐ Divorced "netural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other then eny injury or other treumatic event, If a Ns. College (1-4or 5+) Elementary/Secondary (0-12) Cost Analyst Department of the Navy 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Many Irene Crutchett ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanore M. Many/ Wife 11417 Lund Place, Kensington, Maryland 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 11, 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Colley 500 University Blvd, W. Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Myocardial Infarction 1 Hour /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b Coronary Artery Disease 4 Years Due to (or as a consequence of): Examine the attanding physicien and hed for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes XX No ospital or Attending Physician: 1 hours after death. uneral Director: After this certifical ly filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 [ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D13187 August 9, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Neill Kennedy, M.D. 5530 Wisconsin Avenue, #1400, Chevy Chase, MD 20815 10+1 31. Date filed (Month, Day, Year) 32. Agistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

2006

Document   Document	ex   7. Age (In   96   10c   Y   K   10c   Y   K   10c   Y   K   10c   Y   K   10c   Y   10c   Y	in U.S. 13.  16a. Dece Give life.  TEACHE  19b. Maili 5229 S  Db. Place of Disporcemetery, crest of Disporcement of Disporceme	POTOMA POTOMA If Under 1 Months  If Under 1 Months  Ocation  10f. Zip C  Was Decede If Yes, specification of work DO NOT use CR  TRATHMO Stition (Name matory or oth EMETERY 2. Name and NES-RIN, 800 NEW	Code  20895 ent of Hispanic ( Ty Cuban, Mexic (X) No Special (Occupation ( A done during management of the second	Origin? (Specan, Puerto ity:  ther's Name  ther's Name  Description of Rura  E, KENS	ing  a (First, Middle, al Route Number INGTON, Note	9, 2006  4c. County of MONTGOM MONTGOM 10, Year) 3, 1910  10g. Citizen of W U.S. 14. Race Black Specify: 16b. Kind of Bus NEW YORK ( Maiden Sumame PEPPERI or, City or Town, S MARYLAND 20	9. Birthplace (State Country)  ISF  10d. Inside 1 76  /hat Country?  A.  9. American Indian, k, White, etc.  WHITE  siness/Industry  CITY PUBLIC  9)  BERG  State, Zip Code)  0895  City or Town, State	City Limits es 2 ☑ No
MANOR CARE POTOMAC  Social Security Number  0.70-16-8071  Sual Residence of Decedent  0. State  10b. County  MARYLAND  MONTGOMER  10c. Street and Number  5229 STRATHMORE AVENUE  1. Marital Status  1. Never Married  3. Widowed 4. Divorced  15. Decedent's Ed. (Specify only highest grant Elementary/Secondary (0-12)  7. Father's Name (First, Middle, Last)  JOSEPH  19a. Informant's Name/Relationship (7)  NILLIAM NECHES / SON  10a. Method of Disposition  1 Burial 2 Cremation 3 Marital County  21. Signature of Funeral Service Licenty  Shock, or heart failure. List only commediate Cause (Final)	ex   7. Age (In   96   10c   Y   K   10c   Y   K   10c   Y   K   10c   Y   K   10c   Y   10c   Y	Yrs.  City, Town or Li ENSINGTON  in U.S. 13.  16a. Dece (Give life.  TEACHE  19b. Maili 5229 S  Db. Place of Dispo cometery, cre  VELLWOOD CI HI 111	POTOMA POTOMA If Under 1 Months  If Under 1 Months  If Under 1 Months  Ocation  If Under 1 Months  Ocation  If Under 1 Months  If Under 1 Months  If Under 1 Months  If Under 1 Months  If Yes, Specification	AC  1 Year If Und Days Hours  Code  20895  ent of Hispanic ( fity Cuban, Mexic (X) No Speci  Cocupation ( (X) Acone during me retired)  18. Mo  EVA  (Street and Num  PRE AVENUE e of her place)  Address of Face  IALDI FUNE	Origin? (Specan, Puerto ity:  ther's Name  ther's Name  Description of Rura  E, KENS	ecify Yes or No Rican, etc.)  ing  in (First, Middle, INGTON, Notate)	MONTGOM  In y Year)  3, 1910  10g. Citizen of W  U.S.  14. Race Black Specify:  16b. Kind of Bus  NEW YORK ( Maiden Sumame PEPPERI  Or, City or Town, S  MARYLAND 20  20c. Location - C	9. Birthplace (State Country)  ISF  10d. Inside 1 76  /hat Country?  A.  9. American Indian, k, White, etc.  WHITE  siness/Industry  CITY PUBLIC  9)  BERG  State, Zip Code)  0895  City or Town, State	City Limits es 2 ∑ No
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1000   1000	In the second of	Yrs.  City, Town or Li ENSINGTON  in U.S. 13.  16a. Dece (Give life.  TEACHE  19b. Maili 5229 S  Db. Place of Dispo cometery, cre  VELLWOOD CI HI 111	Months    10f. Zip C    10f. Zip C    1	Code  20895  ent of Hispanic ( fly Cuban, Mexic  Cocupation ( done during me retired)  18. Mo  EVA  (Street and Nurr  PRE AVENUE e of her place)	Origin? (Special, Puerto ify:  ther's Name  ther's Name  E, KENS  08/13/	ecify Yes or No Rican, etc.)  ing  in (First, Middle, INGTON, Notate)	10g. Citizen of W  U.S.  14. Race Black Specify:  16b. Kind of Bus  NEW YORK ( Maiden Sumame PEPPERI  or, City or Town, S  MARYLAND 20  20c. Location - C	ISF  10d. Inside  1  Ye  In American Indian,  White, etc.  WHITE  siness/Industry  CITY PUBLIC  BERG  State, Zip Code)  0895  City or Town, State	City Limits es 2 ☑ No
Sual Residence of Decedent	E  12. Was Decedent Ever Armed Forces? 1   Yes 2 \( \text{S}\) No If Yes, Give Year or Dates:    Ucutation de completed     College (1-4or 5+) 5+   NECHES   Type, Print     Removal from State   Yes     See   Auditure     Auditure   Yes     A	in U.S. 13.  16a. Dece (Give life.)  TEACHE  19b. Mailit 5229 S  Db. Place of Disponentery, cree  JELLWOOD CI  HI 111	Was Decede If Yes, specification of work DO NOT use CR  TRATHMO EMETERY 2. Name and NES-RIN, 800 NEW	20895 ent of Hispanic ( fly Cuban, Mexic  No Special Coccupation ( done during me retired)  18. Mo EVA (Street and Num  RE AVENUE e of her place)  Address of Face IALDI FUNE	ther's Name	ecity Yes or No Rican, etc.)  ing  a (First, Middle, al Route Number INGTON, No Date	10g. Citizen of W  U.S.  14. Race Black Specify:  16b. Kind of Bus  NEW YORK ( Maiden Sumame PEPPERI  or, City or Town, S  MARYLAND 20  20c. Location - C	Inat Country?  A. A. American Indian, k, White, etc. WHITE Siness/Industry  CITY PUBLIC BERG  State, Zip Code)  0895  City or Town, State	City Limits es 2 ⊠ No
MARYLAND MONTGOMER  Oe. Street and Number  5229 STRATHMORE AVENUE  1. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grant proced)  7. Father's Name (First, Middle, Last)  JOSEPH  19a. Informant's Name/Relationship (7)  NILLIAM NECHES/SON  Oa. Method of Disposition  1 Burial 2 Cremation 3 Married  4 Donation 5 Other (Specify 21). Signature of Funeral Service Licenty Shock, or heart failure. List only commediate Cause (Final)	E  12. Was Decedent Ever Armed Forces? 1   Yes, Give Year or Dates: lucation de completed)  College (1-4or 5+)  5+  NECHES Type, Print)  Removal from State b)	in U.S. 13.  16a. Dece Give life.  TEACHE  19b. Mailit 5229 S  Db. Place of Dispocemetery, cre- VELLWOOD CI HI 111	Was Decede If Yes, specification of work DO NOT use CR  TRATHMO EMETERY 2. Name and NES-RIN, 800 NEW	20895 ent of Hispanic ( fly Cuban, Mexic  No Special Coccupation ( done during me retired)  18. Mo EVA (Street and Num  RE AVENUE e of her place)  Address of Face IALDI FUNE	ther's Name	ing  a (First, Middle, al Route Number INGTON, Note	U.S.  14. Race Black Specify:  16b. Kind of Bus  NEW YORK ( Maiden Sumane PEPPERI  Or, City or Town, S  MARYLAND 20  20c. Location - 0	/hat Country?  A.  A. American Indian, k, White, etc.  WHITE siness/Industry  CITY PUBLIC  BERG  State, Zip Code)  0895  City or Town, State	es 2 M No
0e. Street and Number  5229 STRATHMORE AVENUE  1. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  15. Decedent's Ed (Specify only highest grant status)  7. Father's Name (First, Middle, Last)  JOSEPH  19a. Informant's Name/Relationship (7a)  VILLIAM NECHES / SON  10a. Method of Disposition  1 ☒ Burial 2 □ Cremation 3 ☒  4 □ Donation 5 □ Other (Specify or heart failure. List only commediate Cause (Final)	E  12. Was Decedent Ever Armed Forces? 1   Yes 2 \( \text{No If Yes, Give Year or Dates:} \)  Iucation de completed)  College (1-4or 5+)  5+  NECHES  Type, Print)  Removal from State  1)  See  1  Audumg	in U.S. 13.  16a. Dece (Give life.)  TEACHE  19b. Mailit 5229 S  Db. Place of Dispocemetery, cres  JELLWOOD CI  22  HI 111	Was Decede If Yes, specification If Yes, specification If Yes 26  Ident's Usual skind of work DO NOT use IR  ITRATHMO In It IT I I I I I I I I I I I I I I I I I	20895 ent of Hispanic ( fly Cuban, Mexic  No Special Coccupation ( done during me retired)  18. Mo EVA (Street and Num  RE AVENUE e of her place)  Address of Face IALDI FUNE	ther's Name	ing  a (First, Middle, al Route Number INGTON, Note	U.S.  14. Race Black Specify:  16b. Kind of Bus  NEW YORK ( Maiden Sumane PEPPERI  Or, City or Town, S  MARYLAND 20  20c. Location - 0	A. A. American Indian, k, White, etc. WHITE Siness/Industry  CITY PUBLIC B) BERG State, Zip Code) 0895 City or Town, State	
1. Marital Status  1. Marital Status  1. Never Married 2 Married  3. Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)  7. Father's Name (First, Middle, Last)  JOSEPH  19a. Informant's Name/Relationship (7)  VILLIAM NECHES/SON  10a. Method of Disposition  1 Burial 2 Cremation 3 3  4 Donation 5 Other (Specify  21. Signature of Funeral Service Licenty  Shock, or heart failure. List only commediate Cause (Final	12. Was Decedent Ever Armed Forces?  1	16a. Dece (Give life.) TEACHE 19b. Maili 5229 S Db. Place of Dispo cometery, cre- VELLWOOD CI	Was Decede If Yes, specification If Yes, specification If Yes 26  Ident's Usual skind of work DO NOT use IR  ITRATHMO In It IT I I I I I I I I I I I I I I I I I	20895 ent of Hispanic ( fly Cuban, Mexic  No Special Coccupation ( done during me retired)  18. Mo EVA (Street and Num  RE AVENUE e of her place)  Address of Face IALDI FUNE	ther's Name	ing  a (First, Middle, al Route Number INGTON, Note	U.S.  14. Race Black Specify:  16b. Kind of Bus  NEW YORK ( Maiden Sumane PEPPERI  Or, City or Town, S  MARYLAND 20  20c. Location - 0	A. American Indian, k, White, etc. WHITE siness/Industry CITY PUBLIC e) BERG State, Zip Code) 0895 City or Town, State	
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mmediate Cause (Final	one cause on each line.	Journ. Do not on						MARYLAND 2 Approxim	
				or dying, such a	as cardiac c	n respiratory ar	1631,	Interval B Onset an	letween
disease or condition esulting in death)	a. CONGESTIVE HI		RE					20 YEA	RS
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any, leading to immediate ause. Enter Underlying cause (Disease or injury	Due to (or as a con	sequence of):						JU IEA	N.D
Cause (Disease or injury nat initiated events	с.								
esulting in death) Last	Due to (or as a con	sequence of):							
	d								
F FEMALE:							-1:		
3b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	Fetal death 3	Ectopic preg				23d. Date Mont	of delivery th Day	Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at time 9□ Unknown	of death 5	Other (spec	cify)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ui Duy	, oui
art II. Other significant conditions co	ontributing to death but not	resulting in the u	nderlying cau	use diven in Par	rt I	23e. Did to	bacco use contrib	bute to the cause of	f death?
		•	,,	<b>3</b>					
DEMENITT A						240 1000	0.4h 14/		
						autop	sv pri	ior to completion of	cause of
				OC Die	as of Death	-		Yes 2 No	
examiner?	Hospital: 1 Innatient :	2 ☐ EB/Outnatier	at 3□ DOA	104				. (0-1-4.)	
7. Manner of Death	28a. Date of Injury	28b. Time of							
2 ☐ Accident investigation		r) injury	м		□No				
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of injury - A	At home, farm, str	eet, factory, o	office	2			r or Rural Route Nu	mber,
							•		
(Chack only 2   Medical Cash)	ysician: To the best of my	knowledge, death	n occurred at	t the time, date a	and place, a	and due to the o	ause(s) and mani	ner as stated.	(c)
	and manner stated.								
9b. Signature and title of dertifier	1		29c. l	License number	Г	2	29d. Date signed (	(Month, Day, Year)	
AIN	217		DOC	053615		A	UGUST 10,	2006	
			,	DOCITITE T	144755	LAND GOOG	٦		
ARUNA NATHAN, M.D., 11	125 ROCKVILLE I	PIKE, SUIT	E 208, F	KOCKVILLE	, MARY	LAND 2085	T		
2 1 5 7	9 Unknown  art II. Other significant conditions or ORONARY ARTERY DISEAS  EMENTIA  YPERCHOLESTEROLEMIA  5. Was case referred to medical examiner? 1 Yes 2 (X No  7. Manner of Death 1 (X) Natural 5   Pending investigation of 3   Suicide 4   Homicide    10a. Certifier   (Vincel out)   Text   Medical Examined  2b. Signature and title of dertifier  2b. Signature and address of person who can be called a control one)  2b. Name and address of person who can be called a call	9 Unknown 9 Unkn	9 Unknown  1 Unknown  2 EkvOutpatier  2 Ber/Outpatier  2 Description  3 Date of Injury  2 Ber/Outpatier  2 Description  3 Date of Injury  2 Ber/Outpatier  2 Descript	9 Unknown  1	9 Unknown  1 In	9 Unknown  art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  ORONARY ARTERY DISEASE  EMENTIA  YPERCHOLESTEROLEMIA  5. Was case referred to medical examiner?  1   Yes 2   Xho	9 Unknown  Int II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did to CORONARY ARTERY DISEASE  I UY  EMENTIA  24a. Was a autop perfor I Ves 2 No  Hospital: I Inpatient 2 EP/Outpatient 3 DOA  Manner of Death Month, Day Year)  Manner of Death Month, Day Year)  Month, Day Year)  28b. Time of Injury Mork? Month, Day Year)  28c. Injury at Work? Month, Day Year)  28d. Describe holding, etc. (Specify)  Do Signature and title of detriffier  29c. License number   9 Unknown 1 Yes 2 No 28 Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No 1 YPERCHOLESTEROLEMIA 5. Was case referred to medical examiner? 1 Yes 2 No 1   Hospital:   I   Inpatient   2   EP/Outpatient   3   DOA   Other   4 Nursing Home   5   Residence   6   Other   4 Nursing Home   5   Residence	9 Unknown 9 Unkn	

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Isadora Susan Pa	1	er - For State legistrar	Sta	te of Maryla		artment o rtificate of		d Mental H		g. No.	200	6 2	715
Physician	1/	1. Decedent's Name	(First, Middle	,Last)					Date of Death     Month	n Day	Year	3. Time of Dea	
Medical Examin		Isadora					4b. City, Town, or	Leading of Doot	August 8, 2		unty of Death	,	·
•	ľ	4a. Facility Name (r 605 Ivy Lea		, give street and nu	mber)		Rockville	Location of Deat	1		tgomery		
Funeral	4	5. Social Security N		6. Sex	7. Age (In yrs	last birthday)	If Under 1 Yea	ar If Under 24Hr	s. 8. Date of Birt	h(MM/DD/			or
Director		212-50-02	210	1 M 2X F	52	Yrs	Months Day	s Hours Mir	April 2	28,195	54 Foreig	untry) MD	
	E	Usual Residence of	Decedent									404 Include C	its Lucasta
w any			10b. County		1	, Town or Local	ion					10d Inside Ci	
rland	cto	MD 10e. Street and Nu	Montgo	mery	Roc	kville	10f. Zip Code	<u>.                                    </u>	110	)a Citizen	of What Cour		
the Ma ha or 23		605 Ivy		Lane			20850			U.S.A			
ath with	Funeral	Marital Status     Never Marrie	ed 2 X Ma	rried Armed F			as Decedent of His es, specify Cubar				Race - Ameri White, etc.	can Indian, 81a	ack,
iter de		3 Widowed	4 Divo	1 Yes  If Yes, Give Yes  or Dates:	2 X No	1	Yes 2X No	specify:		Spe	ecify: Wh	ite	
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21215-0036 uld be filed within 7 Mental Hygiene marked other than event, the Medica	Completed	17. Father's Name	/Eiret Middle	5+		Homem	aker	18.Mother's Nam	e (First, Middle, N		n Home		
115- e filed al Hyg red oth	BeC	Sylvan P		Lasty					Lazrius		,		
212 212 Ould be Ment mark	랅	19a. Informant's Na	ame/Relationsh	nip (Type, Print )		19b Mailin	g Address (Stre	et and Number or	Rural Route Num	ber, City o	r Town, State	, Zıp Code)	
MD and 2 shc alth and m 27 is aumati	l	Marc J.		- Husban			vy Leagu					7 01-1-	
re, s I and f Heal If iten		20a. Method of Dis 1 X Burial 2		3 Removal fi		Place of Dispo crematory or o	sition (Name of ce ther place)	emetery,	Date	20c. Loca	ation - City or	Town, State	
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Baltimore, permit Pages I an Department of Hea Important: If iten injury or other it	У	21. Signature of Fu	. W	Licensee		10	Name and Addres	<sup>is of Facili</sup> Edwa 7i11⊖ Pil	ard Sage	l Fun	eral D	irectio	on
Physician	-	23a. Part I. Enter th	ne disease	plications that o	caused the deat							Approximate	
/Medical		failure List or Immediate Cause	nly one ca s	n each line. a Hanging								Between O Dea	
Examiner		or condition resulti			a consequence	of):							
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Box 68760, e death certificate be the attending physicied for use as the burned for use	ğ	IF FEMALE: 23b. Was decedent	pregnant in th	•	outcome of pre						ate of deliver	,	Vaar
Sox 6876  death certificate e attending phy for use as the l	sician/M	past 12 month	s?	1	birth nant at time of c	dooth	etal death 3 other (Specify)	Ectopic preg	nancy	Mo	onth	Day `	Year
Box e death the atte	ysic	1 Yes 2	No 9 🗸 Unk	nown 9 Unkr	nown	3 🗌 0	Title: (Opcony)						
o. I hat the ed by the etache	y Phy	Part II. Other sign	ificant conditi	ons contributing	to death but not	t resulting in the	underlying cause	given in Part I				the cause of d	
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Vital Rec ysician: The his certificate director, page	Be	25 Was case refe examiner?	rred to medical	Hospital:			/	Other			- [4] - :		
of Vit ing Physic After this	2	1 🗸 Yes	2 No		Inpatient 2	ER/Outpatier		ury at Work?	28d Describe		occurred	r Scene	
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isio Atten er deat rector by the	icat	2 Accident	Inves	stigation Aug 8,		1629 hrs home, farm, str	eet, factory, office	building, etc.	28f. Location (	Street and	Number or R	ural Route Nun	nber, City
Division pital or Attent ours after death neral Director:	Certification:	3 ✓ Suicide 4 Homicide		d not be (Specify	) Single Fa	amily			or Town, S 605 Ivy Lea	<sub>State)</sub> gue Lan	e, Rockvil	le, MD	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier	Certifying Pl	nysician: To the be miner:On the basis	est of my knowle	edge, death occ	urred at the time,	date and place, a	nd due to the caus	se(s) and m	nanner as sta	ted	
To th within	Medical	29b. Signature an		and manner	stated			nse number				onth, Day, Year)	)
	2	250. Signature and	A				l	c.M.E.		1	st 9, 2006	, 22), (001)	
		Tamely,	Willia.	who cometed car	use of death / lea	em 23a)	1			1			
12	2	Pamela Sc		Assistant M			Penn Street,	Baltimore, M	D 21201				
	ate		na Pax Year)	2006 32.	egistrar's Signi	ature	ver						
Regist	rar		- TOU I	2000	BESINE .	10. W.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** :35 /DM NON ARKER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery
9. Birthplace (State or Foreign Country)
1938 Washington, DO Riderwood Village Nursing Home 8. Date of Birth (Month, Day Year) 1938 Silver Spring
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours 1 →M 2 □ F Months 68 219-34-8217 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c, City, Town or Location 7 ia markad othar than "natural", or itama 23a or 28a-f ahow traumatic avant, the Madical Examinar must be notified at 1 √2 Yes 2 □ No Director MD Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3158 Gracefield Rd. #FC-506 20904 United States Funerai permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 272No ff Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Specify: White 1 ☐ Yes 2 🖾 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Architect Independent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thornton Jenkins Parker Jr. Margaret Howard Kerr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4615 Ellicott St. NW Washington, DC 20016 Thornton Parker / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 08/10/2006 Falls Church, VA National Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Fungant Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 May Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) na 71 almina Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit the death certificate be executed Due to (or as a consequence of): Physician/Medicai use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 page 2 should be 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed peed : 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No this certificate has 2 Alo 1 ☐ Yes or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Yes 2 ☐ XIO 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending s efter death. investigation М 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funeral C To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b, Signature and title of cer DOCK 3375

Registrar DHMH 17 Rev 1/2001

State

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Division of Vital Records, P.O. Box 68760.

3160 Gracefield Rd. Silver Spring, MD 20904

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

2006

32. Registrar's Signature

Karen Merritt MD

AUG 11

31. Date fifed (Month, Day, Year)

			1 - For State Registrer	State of M	aryland	d / Depa <i>Cer</i>	rtmen tificate	t of H	ealth a	and M	lental Hyg	giene Beg. No.	2006	27158
	Physic		1. Decedent's Name (First, Middle, Las John Alfred Przy	•							2. Date of Dea Month	ith Day		3. Time of Death 9:45 P M
1	/Medi Examir		4a. Fecility Name (If not institution, give 149 Nautical Lan	street and number)	)			Town, or	Location o	of Death	0	4c.	County of Deal	h
	Funeral Director		5. Social Security Number 6. Se		95	ast birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 10/30/	Year)	9. Birt	hplace (State or Foreign buntry) Mass.
	e Maryland Sa-f ehow tiffed at	Director	10a. State 10b. County  MD Worceste	r		n City				-				10d. Inside City Limits XX Yes 2 □ No
	th with th	ai Dire	10e. Street and Number 149 Nautical Lane				10f. Zip	Code 842				10g. Citiz USA	zen of What Co	ountry?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Iteme 23s or 28s-f show any Injury or other traumatic event, the Medical Examinar must be notified at ance.	d by Funeral	11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes ※XX If Yes, Give Year or Dates:	•	If	Vas Deced Yes, spec □ Yes		spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	1	14. Race - Ame Black, White Specify: White	e, etc.
Maryland 21215-0036	d within 72 h giene. ir than "natu the Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or: 2	5+)	life. D	ent's Usua kind of wor OO NOT us 1ager	k done di	uring most	of worki	ng		nd of Business/	
yland;	ould be filed Mental Hyg larked othe	To Be C	17. Father's Name (First, Middle, Last)  Jan Josef Przyby						Apo1	onia	(First, Middle, Zarnow	Maiden : ski	Sumame)	
	and 2 sh leelth and m 27 ie m		19a. Informant's Name/Relationship (T. Ruth Przybyla (wi		last Bu	149 N	autic	al I	Lane	0cea	n City,	MD	21842	
Baltimore,	t. Pages 1 tment of h rent: If Ite		20a. Method of Disposition  1 ☐ Burial ② ☐ Cremation 3 ☐ I  4 ☐ Donation 5 ☐ Other (Specify,			ace of Dispos ometery, crem e Hen1	open	Crem	ı. 0	8/14			kford,	
Bal	permi Dapa Impo		21. Signature of Funeral Service Licens  26a Part 1 Filter the disease or comp	Y Da	fort	Zi 10	Name and	lian	Str	eet	bage Fun Berlin,	MD	1 Home 21811	Approximate
	Physician /Medical Examiner  the purial-transit stress in the purial-trans	i Examiner	23a. Part 1. Enter the disease, or comp shock, or heart befure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Failur  Due to (or as  b. STR  Due to (or as  c. Due to (or as	e to a conseque A Conseque a conseque	thrive ence of):	RILL	ATI	N					Interval Between Onset and Death
O. Box 68760	The law requires that the death certificate to the has been signed by the attending physic age 2 should be detached for use as the board.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 5 & Wf	of pregnan	ncy death 3 🗆 l	Ectopic pre Other (spe		N (	9 8	THE	-	3d. Date of deli Month	very Day Year
عد	tuires that the signed by the detact	þ	Part II. Other significant conditions co	ntributing to death b	ut not resul	lting in the un	derlying ca	use giver	n in Part I.		23e. Did tot			the cause of death?
Vital Records,	10	Completed	Atrial Flutter								24a. Was a autops perform	y	24b. Were au prior to o death? 1 \( \text{Yes}	topsy findings available ompletion of cause of
ō	or Attending Physiclen: I ifter death. Director: After this certifical In by the funeral director, p	ation: To Be	27. Manner of Death XXNatural 5 Pending 2 Accident investigation	1 ☐ Inpatie 28a. Date of Inju (Month, Da	rv 2	P/Outpatient 28b. Time of Injury		Other c. Injury : Work?	: 4 ☐ Nur	sing Hon 2	Check only on ne 5∑ Reside 8d. Describe ho	nce 6		ify)
DIVISION	spital or Atti tours after de nerel Directe filled in by ti	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	c. (Specify)					Ja	City or Town	, State)		ral Route Number,
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	Twit To	_	29b. Signature and title of certifier	my			D28	798	number				signed (Month	, vay, Year)
{	3A 15		30. Name and address of person who contains C. Gonzalez	, MD 314	Frank	lin Av		ite	104	Berl:	in, MD 2	2181	1	
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 1 5 2	32. Registra		# A	mode	,						

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Physicia	an/																	
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and the same of th		4a. Facility Name (		_	treet and n	umber)		41	o. City, Town		ocation of	Death			County of D			
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iten ust b	rue	1 Never Marri	ed 2 M	arried	Armed F	Forces?	No	If Ye	es, specify Cu	uban, N	Mexican,	Puerto Ri	ican, etc.)		White, e	tc.		
fier d		3 Widowed	4 X Div	orced If	Yes, Give Ye			1	Yes 2X	No	specify:			s	pecify: W	hit	:e	
urs a Itura amin	d b	15. Decedent's E	ducation (Spe			ade comple	eted) 16a		s Usual Occ					16b. Kir	nd of Busin	ess/In	dustry	
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ed w ed wyggie other	ဝိ	17. Father's Name	(First, Middle	, Last)						18	Mother's	Name (f	irst, Middle	, Maiden S	urname)			1
21215-0036 Motd be filed within 72 hours after hard Hygiewith marked other than "natural", event, the Medical Examiner	Be	George	Frankl:	in Do	ougla	.s							Joan A					
21 hould nd Me is ma	ဥ	19a. Informant's N	ame/Relations	ship (Typ	e, Print )		1	9b Mailing	Address (S	Street a	and Numb	er or Ru	ral Route N	umber, City	or Town, S	State,	Zip Code)	
MD ; id 2 shou lith and m 27 is a		George	F. Doug	glas	- Fa	ther			Brian									
nore, MD 2 ages I and 2 shou nt of Health and N t: If item 27 is n other traumatic		20a. Method of Dis		n 3	Pemoval	from State		e of Disposi atory or oth	tion (Name o er place)	t ceme	etery,		Date	20c. Lc	cation - Ci	ty or I	own, State	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Helath and Mental Hygiente near file and Mental Hygiente and "natural", or items 23a or 28a-f sho are if if item 27 is marked offer than "natural", or items 23a or 28a-f sho are other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5			Romovar	nom otato	Rest	Haver	n Ceme	ter	у	8/25	/06	Hag	ersto	wn ,	, Mary	land
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he de y the	<u>چ</u> ا	Part II. Other sign			- L		ut not result	ing in the u	nderlying ca	ise div	ven in Pa	rt I	23e. Dio	I tobacco u	se contribu	te to t	he cause of	death?
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Division of Vital Records, P.O tal or Attending Physician: The law requires that the staffer death.  The Directors Affer this certificate has been signed by the funeral director, page 2 should be deace dear of bein by the funeral director, page 2 should be deace.		27. Manner of Dea	ath		28a. Da (Mor	te of Injury nth, Day,Yea	281	o. Time of I	njury 28c		at Work		28d. Describ	e how injur	y occurred			
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death. To the Funeral Director. Affer this certificate has been signed by the attending physician and completely filted in by the funeral director, page 2 should be detached for use as the burial - transi		29a Certifier 1							red at the tin									
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		30 Name and ad	dress of perso	n who co	mpleted ca	ause of dea	ath (Item 23a											
		Pamela So				/ledical E	Examiner	111 F	Penn Stree	et, Ba	altimore	e, MD 2	21201					
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State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registrar 27160 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Katherine Ross August 15 2006 2:25P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner 400 Nashold Place Greensboro Caroline If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🗓 F Yrs. Director 214-34-8742 81 Aug 30 1924 Delaware Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts item 27 is marked other then "neturel", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No Director Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Nashold Place 21639 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. be filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker 0.8 own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of Charles F. Witt Luzetta Hughes Alfree Witt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth Bonnie Spiering, granddaughter 26621 Boyce Mill Road Greensboro, Maryland 21639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of H Important: if its eny injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Aug 20 2006 4 ☐ Donation 5 ☐ Other (Specify) Ridgely, Maryland Ridgely Cemetery 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner astery stenoses Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine law requires that the death certificate be executed ettending physicien and for use as the burial-transit trerosc that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 200

9 Unknown Day 4□Pregnant at time of death P.O. F 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by ischemia Yes 2 No 3 Probably 4 Unknown obstructive pulminary disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1□ Yes 20 No certificete 1 ☐ Yes 2 ☐ No or Attending Physicien: : After this certification funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending efter death.

Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours of To the Funeral D completely filled in Hospital 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the nausc(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29b. Signature and title o 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 S. Washingtondt Easton mo 2160/ Actor mo ANDREA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State (costs) Registrar AUG 1 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death **Physician** alm /Medical Facility Name (If not institution 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs, last birthday)
Yrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day **Funeral** 1 M 200 F Days Hours Director Usual Residence of Decedent 10a. State 10b. County If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Be Completed by Funeral Director 1 Pres 2 No 10e. Street and b 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No 1 Neyer Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic svent, ODCs. 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 100 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dear Immediate Cause (Final **Physician** disease or condition louth /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dire to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 🗌 Yes 2 NO 3 Probably 4 Unknown funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 20 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Certification: To 1 Tes 2010 Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient this 3 DOA 4 Sing Home 5 ☐ Residence 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injun Director: A investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) dress of person who completed wuse of death (Item 23a) (Type, Frint) 12 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar - 2006 DHMH 17 Rev 1/2001 **ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2006

State of Maryland / Department of Health and Mental Hygiene 2006

Certificate of Dooth 27162 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month Year ANNA CATHERINE ROLLINS JULY /Medical 2006 12:01 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner LAPLATA

If Under 1 Year If Under 24 Hrs. CIVISTA MEDICAL CENTER CHARLES 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🂢 F Yrs Director 215-52-5999 MAR. 22, 1929 VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow the Medical Examiner must be notified at 1 Yes 2 V MARYLAND CHARLES CHARLOTTE HALL Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 238 8525 ROUND HILL ROAD 20622 U.S.A. Funeral Heme 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married ŏ 1 ☐ Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry le marked other than Elementary/Secondary (0-12) College (1-4or 5+) 11 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Health and Mental THURMAN Ε. THOMPSON IDELL P. FITZGERALD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health at Importent; If tem 27 le eny injury or other trauone. JAMES P. ROLLINS-SPOUSE 8525 ROUND HILL RD., CHARLOTTE HALL, MD2062? 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State 4 ☐Donation 5 ☐ Other (Specify) DENTSVILLE METH. CEM. 8-3-06 DENTSVILLE, MD 21. Signature of Funeral S, rvice Licentee 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, LA PIATA, MARYLAND 20646 23a. Fart1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause 10 ch line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Intervat Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician HRONIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (us as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical ęų, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the ber O 9 Unknown s been signed by the should be detache 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2) (No 1 Yes 2 No 1 Tes Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient To 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Injury at Work? ospitar .
4 hours after dea..
-rel Director; Afr 1 XNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funerel I
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 7-31-2006 D-26064 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIDYAASAGAR ANMANGANDIA MD. 10583 THEODORE GREEN BLVD. WHITE PLAINS MD 20695 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 8 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 106 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month COO AM izabeth Shrieves 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 6. Sex 7. Ag (In yrs. last birthday) **Funeral** 1 □ M 2 F Days Months 3105 Director Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or items 23a or 28a-f show any injury or other treumatic event, the Madical Examinar must be neithlised at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits na Funeral Director PQYes 2 □ No VZYO. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 20 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Aide Hone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Cool) JEAN DR.Ve , NOSON M md 21244 20a. Method of Disposition 1 Seurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 106 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine use as the burial-transi Cause (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autoosy perform 1□ Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Volursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certiffer Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2006

D 37333

54.00 OLD COUNT NO, MD 21133

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 22, 2006 0300 Physician Harvey Irving Showe, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 402 Pearl Street Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. Oct. 16, 1925 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ xx 2 □ F 219-12-0495 80 Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Iteme 23a or 28a-1 ehow any Injury or other traumatic event, the Modical Examinar must be notified at once. 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Frederick Frederick 1 XYes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 402 Pearl Street U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Na Yes 2 No 1943 to 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Yes, Give Year or Dates: 1946 1 ☐ Yes 2√☐ No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sports and Recreation Director U. S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hattie Harris Harvey Reno Showe, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7502 Fingerboard Road, Adamstown, Maryland 21710 19a. Informant's Name/Relationship (Type, Print) Kathi S. Geisbert/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State August 25, 2006 Frederick, MD 4 Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Keeney and Basford Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. MD 21701 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** anced /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sete hes been signed by the ettending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown certificate has been signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2□ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \( \to \) Nursing Home 5 \( \overline{\text{Residence}} \) 6 \( \to \) Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide ŏ To the Hospital of within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D41866 August 23, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kanan Hudhud, M.D., 46-B Thomas Johnson Drive, Frederick, Maryland 21702 31. Date filed (Month, Day, Year)
AUG 2 8 2006 32. Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2006Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Lucille 19, 2006 11:45A M August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges 8320 14th Avenue Hyattsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Peb. 22, 1925 9. Birthplace (State or Foreign Country) VA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 234-40-6481 81 Yrs Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "neture", or items 23s or 28s-f show the Medical Examiner must be notified at TX Yes 2 No MD Director Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8320 14th Avenue United States 20783 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No δ Specify: 3 ☐ Widowed 4 [XDivorced Black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Housekeeper 12 or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked oth any linury or other treumatic event spice. Be Napolean B. Martin Effie Francis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13019 Chalfont Avenue Fort Washington, MD. Philip Martin/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cem. 8/25/06 Suitland, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrest /Medical Due to (or as a consequence of) Examiner Arteriosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 2 No 23d. Date of delivery 3 Ectopic pregnancy ned by the atter Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? hes autopsy performed? certificate 1 Yes 2X No 1 ☐ Yes 2 No To the Hospitel or Attending Physicien: tor: After this certific the funeral director, To Be 25. Was case referred to medical examiner? 26. Place of Death. (Check only one) Hospital: Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 XYes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after de To the Funerel Directo completely filled in by th 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D0009357 August 23, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 14300 Gallant Fox Lane, Bowie, MD. #126 J. Richard Lilly,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Molifin, Day, Teal)

AUG 2 8 2006

324

State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month AUGUST **Physician** 18, 2006 11:25A M TANNER DONALD SPENCER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CALVERT CALVERT MEMORIAL HOSPITAL PRINCE FREDERICK If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 ⊈M 2 ☐ F Director 215-62-2855 OCT.12,1953 VIRGINIA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a State 10b County item 27 is marked other than "natural", or items 23a or 28a-1 ehow other traumatic event, the Madical Exertires must be notified at 1 ☐ Yes 2 No HUNINGTOWN CALVERT MARYLAND Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 20369 6010 STEPHEN REID RD. U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Heatth and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 23 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽÜNo Specify: Specify: þ WHITE 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coltege (1-4or 5+) Elementary/Secondary (0-12) BUILDING MAINTENANCE OWN SELF 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) WILMA IRENE CHARLES WALTER SPENCER BAKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 Is any injury or other trat once. RICHARD W. SPENCER-BROTHER 4000 FOXBURROW PL., POMFRET, MD 20675 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ※ Moremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) MF.T. METROPOLITIAN CREMATORY 8-21-06 LALEXAURIA, VA M 10 17 9 22. Name and Address of Facility 21. Signature of Juneral Service Licensee RAYMOND FUNERAL SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Ceath Immediate Cause (Final respirator Physician cute disease or condition resulting in death) /Medical Examiner cute cholegatit day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The taw requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. ears Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown n signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ coholism 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed hepatitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has l autopsy performed 1 ☐ Yes 2 ☐ No certificate 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this After thi 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: / 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours a 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2006 18 060390 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20678 HOSPITAL PRINCE FREDERICK ADEEB JABER 100 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 2 8 2006

ORIGINAL

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar  Certificate of Death Reg. No. 2006 2716
			1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death
П	Physici		James E. Savage Sr. Hygns 10, 2 4, 40)
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. Country of Death  Baltimore Washington Marker Company  4b. City, Town, or Location of Death  Bank Bruns de
	Funeral Director		5. Social Security Number 220-28-7416  6. Sex 7. Age (In yrs. last birthday) Nonths 74 Yrs.  7. Age (In yrs. last birthday) Nonths 10 Days 10 Days 11 Dider 1 Fear 11 Under 24 Hrs. Nonths 12 Days 13 Days 14 Days 15 Days 16 Days 17 Days 18 Date of Birth (Month, Day, Year) 18 Days 19 Birthplace (State or Foreign Country) May 3 1932  Maryland
	and w		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limits
	Maryli 1 eho	ōI	Maryland Anne Arundel Crofton 1□Yes 2次No
	28a-	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	3a or		917 Eastham Ct. Apt T2 21114 USA
	death	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
Maryland 21215-0036	hours after death with the Maryland tural', or Items 23a or 28a-1 ehow at Exeminat must be notified at	Ď	Amed Forces?  1 Never Married 2 Married  3 Widowed 4 Divorced  Amed Forces?  1 Never Married 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes, Specify:  1 Yes, Specify:  1 Yes 2 No It Yes, Specify:  1 Yes 2 No Specify:  Specify: Black, White, etc.  Specify: Black, White, etc.
5-0	72	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working
121		m jd	Elementary/Secondary (0-12) College (1-4or 5+)
22	be filed within tal Hygiene. In other then event, the Miles		11th 0 Heavy Equipment Operator Sanitation  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surmame)
and	Mental Merked o	To Be	William H. Savage Irene Torney
3	should nd Men marke	F	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	aith a aith a 27 is		Iva Savage(Wife) 917 Eastham Ct. Apt T2 Crofton, Md. 21114
ore,	es 1 and 2 should b of Health and Ment of Item 27 is marked ir other traumatics		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State
Ĕ	Pages nent of I ant: If It ury or o		4 Donation 5 Other (Specify) Maryland Veteran 8-16-06 Crownsville, Md.
Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		21. Signature of Funeral Service Licensee  Wm. Reese & Sons Mortuary, P.A.  821 West St. Annapolis, Md. 21401
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate
	Physician		Immediate Cause (Final disease or condition resulting in death)  a
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):
Н	LAdimine	_	Sequentially list conditions b.
	ped nsit	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Oisease or injury
_	be executed sician and burial-transit	Examiner	that initiated events consequence of):
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89	g physi as the t	edic	
ŏ	eath certific attending p for use as	N/U	IF FEMALE: 23b. Was decedent pregnant in the part 12 months?  23c. If yes, outcome of pregnancy  23d. Date of delivery  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
.O. Box 6	the d y the iched	Physician/Me	in the past 12 months?  1   Yes 2   No 9   Unknown   Year   Unknown   Month Day Year    9   Unknown   Month Day Year   Month Day Year    9   Unknown   Month Day Year    9   Unknown   Month Day Year    1   Yes 2   No 9   Unknown   Month Day Year    1   Yes 2   No 9   Unknown   Month Day Year    1   Yes 2   No 9   Unknown   Month Day Year    1   Yes 2   No 9   Unknown   Month Day Year    1   Yes 2   No 9   Unknown   Month Day Year    1   Yes 2   No 9   Unknown   Month Day Year    1   Yes 3   No 9   Unknown   Month Day Year    1   Yes 3   No 9   Unknown   Month Day Year    1   Yes 3   No 9   Unknown   Month Day Year    1   Yes 3   No 9   Unknown   Month Day Year    2   Yes 3   No 9   Unknown   Month Day Year    3   Yes 4   No 9   No 9   Unknown    4   Yes 4   No 9   No 9   Unknown    4   Yes 5   No 9   Unknown   No 9   Unknown    4   Yes 6   No 9   Unknown   No 9   Unknown    4   Yes 7   No 9   No 9   No 9   Unknown    4   Yes 8   No 9   No 9   No 9   No 9   No 9    4   Yes 8   No 9    4   Yes 8   No 9   N
٥,	es thet igned b	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
rd	w require been sig should b	pe	That I les 2 No 3 Probably 4 Unknown
Division of Vital Records,	The law requires thet sete has been signed b page 2 should be deta	Completed	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
ital		0	1   Yes   25 No   1   Yes   25 No   25 No   25 Was case referred to medical   26 Place of Death (Check only one)
<b>*</b>	sis di	To B	examiner? 1   Yes 2   No
0 _	ng Ph ster th meral		27. Manner of De th 28a. Dale of Injury 28b. Time of Injury Work? 28b. Time of Injury Work?
sio	tendi leath. tor: A the fu	cati	2 Accident investigation M 1 Yes 2 No
Divi	tal or Attending PP rs after death. al Director: After the	Certification;	3 Statistics of
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera	Medicai	29a. Certifier  (Check only one)  TE. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the To the Comp	Σ	29b. Signature and title of centrier 29c. License number 29d. Date signed (Month, Day, Year)
		17	) 1800 p 108/10/2006
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Dra, Glen Burnit
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature

		1	For State Registrar	State of Maryland	/ Depa	rtment of H	lealth and Death	Mental Hyg	piene 200	6 27168
Phys /Me	iciar dica	i	Decedent's Name (First, Middle, Last)		hmid	t, Jr		2. Date of Dea Month 08	Day 04 Yea	3. Time of Death 4:45p <sup>M</sup>
	nine		ia. Fecility Name (If not institution, give si William Hill Manor  5. Social Security Number 6. Sex		• friesh ada)	4b. City, Town, or Easton  If Under 1 Year	Location of Dea		4c. County of D	:
Funer Direct				M 2 F 7. Age (In yrs. last	Yrs.	Months Days	Hours Mir		Year)	Birthplace (State or Foreign Country) PA
Inition (e.g., Initial yialling Z.I.Z.13-0030 Init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland criment of Health and Mental Hyglene. criment of Health and Mental Hyglene. The Maryland of the theory of the Maryland Explinity or other treumatic event, the Maryland Explinity or other treumatic events.	To Be Completed by Erneral Director	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	1 Never Married	completed) College (1-4or 5+) 5+  idt e, Print) Schmidt/ Wife 20b. Plac	13. V ff 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	aston  10f. Zip Code  21601  Jas Oecedent of H Yes, specify Cuba  Yes 2 No  ent's Usual Occup, find of work done of O NOT use retired  Dysician  Address (Street a	Specify: ation fluring most of we 18. Mother's Na Margar and Number or F	Specify Yes or Norto Rican, etc.)  orking  ame (First, Middle, let W. Fer Rural Route Number	Black, W Specify: W 16b. Kind of Busine Medical Maiden Sumame)  Guson City or Town, State	merican Indian, hite, etc.  Thite ss/Industry  e, Zip Code)
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cate be executed  Cate be executed  Example of the purial transit into burial transit	al er	LAMILIE	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d. d.	Due to (or as a consequent	MM per of): A rustice of):	r the mode of dyin for fr chive fr	g, such as cardio	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
requires that the death certificate signed by the attending plants should be detached for use as t	Physiclan/Mad	yalolaliying	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown	ath 3	Ectopic pregnancy Other <i>(specify)</i>			23d. Date of Month	l delivery Day Year
law requires lhat as been signed b	Completed by Pt	ה ליבור בילים br>בילים בילים בי	Part II. Other significant conditions cont Arterior de cube b Investigate bo	ributing to death but not resulting to death but not resulting welfquely wel	ng in the un	derlying cause give	on in Part I.	ereel 1 Ye	es 22No 3	to the cause of death?  Probably 4  Unknown  autopsy findings available to completion of cause of
vicien: The l	Re Com	2	25. Was case referred to medical examiner?	espital:		3C DOA Othe	or /	eath (Check only on	med? death 1 □ Y e)	? es 2□ No
To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funarel Director: After this certificate has been signed by the attending prompletely filed in by the funeral director, page 2 should be detached for use as	Certification: To	-	1  Yes 2 TNo  27. Manny of Death 1  Viatural 5  Pending 2  Accident investigation 3  Suicide 6  Could not be determined	1 □ Inpatient 2 □ EH	b. Time of Injury	28c. Injury Work M 1 🗆	Nursing	28d. Describe ho	ence 6 Other (Some injury occurred or or or other or othe	pecify) Rural Route Number,
To the Hospitel within 24 hours a To the Funerel I completely filled	odical Ca		29a. Certifier 1 Certifying Physi (Check only one) 2 Medicel Examin	cien: To the best of my knowle er: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the timestigation, in my op	ne, date and place pinion, death occ	e, and due to the caurred at the time, da	ause(s) and manner ate and place, and c	as stated. lue to the cause(s)
To th within To th compl	Mo		29b. Signature and title of certifier	Haber )	MD	29c. License	number	2	9d. Date signed (Mo	onth, Day, Year)
0+ VF			WILLIAM H. WOOD, 131. Date filed (Month, Day, Year) AUG 18 20	M.D., 501 DUTC	HMAN'	Print) S LANE, 1	EASTON,	MD 21601		
	State		31. Date filed (Month, Day, Year) 8 20	06	3	o Brown				

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			1- State of Ma	ryland / De	partment of I e <i>rtificate of</i>	Health and N <i>Death</i>		ene2006	27169
	Physici		Decedent's Name (First, Middle, Last)     THOMAS DREXEL SHERWOOD				2. Date of Death Amonth August	3,2006	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number)  Memorial Hospital C  5. Social Security Number  6. Sex  7. Age  220-34-9553	at Easto e (In yrs. last birthda 92 Yrs.	If Under 1 Year	or Location of Death S+ON If Under 24 Hrs. Hours Min.	<u> </u>	4c. County of Death Talba Year) 9. Birth	1
	anyland show		Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or	Location				10d. Inside City Limits
25	the Mary 28a-f sh	ctor	MD TALBOT	EAS	TON				Y Yes 2 No
no	death with the Maryland ms 23a or 28a-f show r must be rediffed at	Dire	10e. Street and Number 48 PARK LANE		10f. Zip Code	1601	10	g. Citizen of What Cou	untry? SA
mon	after death with the Maryle or Itams 23a or 28a-f sho	Funeral Director	11. Marital Status 12. Was Decedent E Armed Forces?	Ever in U.S. 10	3. Was Decedent of I If Yes, specify Cub		pecify Yes or No-	14. Race - Amer Black, White	
1-0036	filed within 72 hours after Hygiene. Ither then "netural", or Ite ent, Ita Medical Exertine	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 N If Yes, Give 3 📆 Widowed 4 ☐ Divorced Year or Dates:	10	1 ☐ Yes 2X No			Specify: WH]	
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O C	ould be filed Mental Hygi arked other atic event, it	Be	17. Father's Name (First, Middle, Last)  WM. THOMAS SHERWOOD				ne (First, Middle, Ma		
$erwo_{\mathcal{O}}$	d 2 should th and Men 7 Is marke traumatic	To	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Street			City or Town, State, Zi	p Code)
0	5 20 25		TERESA S. LEONARD/DAUGHTER		968 DOVER				
J. J. Mor	S to I		20a. Method of Disposition  1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	cemetery, ci	rematory or other pla	ce)		Oc. Location · City or T	
She	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	1				AM FUNERAL	
	<u></u>		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	によりし	200 S. HA	RRISON ST	EASTON,	MD 21601	Approximate
	Physician		shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition	e.	Preums		,		Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to or as a	a consequence of):	1	1	- 1		
· 2.	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):	Marc	CCICN	6417		
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9.0	Attanding Physician: The law requires that the death certificate be executed death. Geath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/M	9 ☐ Unknown  Part II. Other significant conditions contributing to death bu	ut not resulting in the	underlying cause giv	ven in Part I	23e. Did toba	cco use contribute to t	the cause of death?
rds,	w requires that been signed should be de	ed by	itypertection						bably 4 Dunknown
eco Seco	e law requ has been je 2 shouli	Completed					24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
ta F	ician: Thi certificate ector, pag	as l	25. Was case referred to medical			26 Blace of Doot	performe 1 Yes 2	No 1 ☐ Yes	2 No
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o uo	iding P th. : After t		27. Mannerof Death  1 Natural 5 Pending (Month, Day)  2 Accident investigation	Year) 28b. Time Injury	Wor	y at rk? Yes 2 □ No	28d. Describe how	injury occurred	
Division of Vital Records, P.O.	or Attendi	Certification:	3 Suicide 6 Could not be	ry - At home, farm, s . (Specify)			28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	Hospita 4 hours Funerat	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	examination and/or	ath occurred at the tir investigation, in my o	me, date and place,	and due to the cau red at the time, date	se(s) and manner as s a and place, and due to	stated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. Licens	e number	29d	I. Date signed (Month,	Day, Year)
	5-		Mail Sand	m)	DØ	Ø59:76	2 3	8/3/0	5
	5 -		30. Name and audress of person who complete cause of de	atn III 23a) (Type	e, Print)-Ea	ston,	MO	2160	) ]
	Sta Registr		31. Date filed (Month, Day, Year) 32. Pgistral	r's Signature	Parto-				

			for AMEND#22 per FH state Registrar AACO HEALIH DE	State of Maryland	d / Depa <i>Cer</i>	irtment of H tificate of L	ealth and N Death	Mental Hyg	iene 200	6 27170
			1. Decedent's Name (First, Middle, Last,					2. Date of Deat Month	h Day Yea	3. Time of Death
	Physicia /Medic		James	Andrew		Starli	per	August	7,2006	4:45 pm
)	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	1	4c. County of De	eath
			Hospice of the 5. Social Security Number 6. Se	Chesapeake		Linthi If Under 1 Year	C U M If Under 24 Hrs.	O Data of Blats		rundel
	Funeral		5. Social Security Number 6. Se X	M 2□F 59	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Mar 4 1	Year)	Sirthplace (State or Foreign Country) st Virginia
	Director	}	Usuel Residence of Decedent	X 33	1			riai 4 i	)	St viiginia
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Ba-f	Director	MD Anne Ar	undel :	Severn					1 ☐ Yes 2 X No
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	ath w	rai	7820 Citadel Cour			2114			USA	
	ltem Item	by Funeral	11. Maritał Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ∑ No	5.   13. V	Vas Decedent of Hi f Yes, specify Cuba	n, Mexican, Puert	o Rican, etc.)	Black, W	nerican Indian, hite, etc.
39	urs af		3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	I□Yes 2X No	Specify:		Specify:	White
ğ	2 hou	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Deced	ient's Usual Occupa	ation	king	16b. Kind of Busine	ss/Industry
2	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done o		nuig'		
2	filed within 72 hours after death with the Maryland Hygiene. Ither than "naturel", or Iteme 23a or 28a-f ehow ent, the Medical Examiner must be notified at				Polic	e Officer		- (C' 14:44:- 1	Law Enfo	rcement
ğ	be fil od ott	Be	17. Father's Name (First, Middle, Last)  James Lester Star	linor				ne <i>(First, Middle, N</i> n E <b>il</b> een	- '	
<u> </u>	hould d Mer mark mark	ဥ	19a, Informant's Name/Relationship (T)		19h Mailin	n Address (Street			City or Town, State	Zin Code)
Maryland 21215-0036	id 2 s Ith an 27 is i		Michael Starliper			, , , , , , , , , , , , , , , , , , , ,			, MD 2123	
ē,	f Hea	1.5	20a. Method of Disposition	20b. PI		sition (Name of natory or other plac			20c. Location - City	
e E	Page: ent of nt: If i		1 ☐ Burial 2 ☐ Fremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	terrioval itomi State		ematory		-2006	Baltimore	• MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyljane. Department of Health and Hyljane. Department of Health and Hyljane. Department of Hyljane. Department Hyljane. Departme		21. Signature of Funeral Service Licens				!		,Annapolis	
m	20 = 3		Dat f W	7/						
ì			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the death ne cause on each line.	. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	neta	lot	KPM	1 Cell	arcin	7	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):	0 -		-/		
٠		-	Sequentially list conditions,	b. — Due to (or as a consequ	ience of):	end a	U Car	CILOSA		15 405
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0. 20 2 00042	J. J					
	execunand nand ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
8760,	The law requires that the death certificate be executed ate has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit		(	d						
68	ng ph as th	Physician/Medical	IF FEMALE:							
Box	ith ce itendi or use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnate 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date of Month	delivery Day Year
o.	the entry	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5□	Other (specify)			IVIOITE!	54,
<u>a</u> .	hat the		Part II. Other significant conditions co	ntributing to death but not resu	Iltina in the ur	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
ds,	signe d be	dby	•	•	<b>3</b>	, , , , , , , , , , , , , , , , , , , ,		1 □ Ye	s 2 ⊠No 3 □	Probably 4 Dunknown
202	w requir been si should	Completed						24a. Was a	n 24b. Were	autopsy findings available
Be	he lav e has age 2	E C						autops perform	y prior death	o completion of cause of
ta	an: ] tifical tor, p	60	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2 ath (Check only on		es 20 No
<u>&gt;</u>	Attending Physician: r death. ector: After this certifict by the funeral director, i	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	t 3 DOA Othe	er: 4 🗆 Nursing H	lome 5 ☐ Reside	ence 6 Other (S	pecity) House
0 0	ng Pt fter tf meral		27. Manner of Death 1. SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun World	/ at k?	28d. Describe ho	w injury occurred	
sio	tendl leath. Ior: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
Division of Vital Records,	or At after of Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str ')	eet, factory, office		City or Town		Rural Route Number,
_	To the Hospital or Attending Physician: The I within 24 hours efter death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phy	sician: To the best of my know	wledge, death	occurred at the time	ne, date and place	and due to the ca	ause(s) and manner	as stated.
	e Hos	edical	(Check only Z Medical Exem	ner: On the basis of examinat and manner stated.	ion and/or in	vestigation, in my o	pinion, death occu	irred at the time, di	ate and place, and o	lue to the cause(s)
	within 24	Me	29b. Signature and title of cartifier	11/	1	29c. License	e number	) 2	9d. Date signed (Mo	onth, Day, Year)
)			1///	7//		-	1315	7/	August	81046
	7		30. Name and address of person who c	ompleted cause of death (item	23a) (Type,	Print)	1	CIR	JNI	roci
	30		31. Date filed (Month, Day, Year)	32. Jegistrar's Signal	) H	OSpital	WENG,	JEH DW	my /M.	1100
	Sta Registi			006 32. registrar's Signal	K A	ade	,			1

			1 = For State Registrar	State	of Mary	land / [	Departr <i>Certifi</i>	ment of Hocate of L	ealth a Death	nd Me	ental Hyg	ene g. No.	2006	5 27	171	
	Dhusisi		1. Decedent's Name (First, Middle, Li	ast)							2. Date of Deat Month	Day	Year	3. Time of	Death	
	Physici /Medio		Josephine Ches	nut	Spurr						August			11:14	ам	
>	Examin		4a. Facility Name (If not institution, gi					. City, Town, or				4c. (	County of Dea	th		
			15107 Interlach					Silver						tgomery		
	Funeral Director			Sex 1 □ M 2 <b>⊠</b> F	7. Age (In	yrs. last bir 8		Under 1 Year onths Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, April 1:		C	thplace (State o. ountry) 'exas	r Foreign	
_	p.		Usual Residence of Decedent		10									T		
	aryler show	_	10a. State 10b. County		10	c. City, Tow	n or Locatio	on						10d. Inside Cit	•	
Ž.	8e-1	Director	Maryland   Montgom	ery	S	ilver									2 30 140	
	with t		10e. Street and Number 10f. Zip Code 15107 Interlachen Drive, Apt. 115								g. Citiz	en of What C	ountry?			
	death with the Marylend ms 23a or 28e-f show	ara a	44.44.44.101.4	12 Was Dec	andont Ever	o II c	12 14/00		906	in2 (Coo	oily Voc or No	1	USA 4. Race - Ame	nigan Indian		
_	s 1 and 2 should be filed within 72 hours after death with the Marylen if Health and Mental Hygiene Itam 27 is marked other tren "natural", or Itams 23a or 28e-1 show other traumatic event, the Mardical Examinar mant he notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes  If Yes, Giv Year or Div			III U.S.		Was Decedent of Hispanic Origin? (Specify Y f Yes, specify Cuban, Mexican, Puerto Rican, 1 □ Yes 2 ⊈No <i>Specify:</i>			Rican, etc.)	ryes or No- an, etc.) 14. Hace Black		White, etc.		
9500-c	atura	ed	15. Decedent's E	ducation		16a.	Decedent's	s Usual Occupa	tion		1	6b. Kin	b. Kind of Business/Industry			
<u>.</u>	within 72 ene. then na	Completed	(Specify only highest gi	ade completed			(Give kind life. DO N	of work done di IOT use retired)	uring most	of workin	9			,		
7	inth inth	Eo	Elementary/Secondary (0-12)		(1-4or 5+)		Ste	nograph	er		Fe	eder	al Gov	ernment		
<u>D</u>	il Hygi other	Be C	17. Father's Name (First, Middle, Las								(First, Middle, M	laiden S				
land	uld be Mental rked o	To B														
a	should and Men s marks umatic	, ,	19a. Informant's Name/Relationship				-				Route Number,	-		-,, -	0906	
, Ma	s 1 and 2 Health a Itam 27 Is other tra		Warren F. Spurr/	Husban	iđ	1	5107	Interla	chen I	Drive	e, Apt.	115	, Silv	er Spri	ng, M	
aitimore	permit. Pages 1 a Department of He Importent: If Itan eny injury or oth		20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetary, crematory or other place)  Aug. 14,  Gate of Heaven Cemetery													
	artme orten injur		4 Donation 5 Other (Specify)  Gate of Heaven Cemetery 2006 Silver Spring, Maryland  21. Signature of Funeral Service Licenses  Francis Signature of Funeral Home Inc.												/land	
ŭ	Ped Final		YALL S.	rente	D						. W. Sil			« MD 2	0901	
			23a. Part1. Enter the disease, o cor	nplications that	caused the	death. Do							Spriii	Approximate	9	
	Physician		23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final  Non - Small Coll Tune Canada  A vi											Death		
1	/Medical		disease or condition resulting in death)  Non-Small Cell Lung Cancer  Due to (or as a consequence of):											4 Yr		
	Examiner															
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.													
	cuted td ransit	Examine														
ĵ	exec en ar rial-t	EX	resulting in death) Last Due to (or as a consequence of):													
8/PU	certificate be executed iding physicien and ise as the burial-transit	dlcal	d													
٥		Med	IF FEMALE:													
מסמ	it the death certifi by the ettending tached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1								23	23d. Date of delivery  Month Day Year				
3	e death the etten	SIC	1 Yes 2 No	5 🗌 Oth	5 Other (specify)					Month Day Tear						
Ţ.	d by	F.		contribution to	dooth hut no	at rooultion is			- in Dod I		22a Did tab					
Ś	w requires that the been signed by th should be detache											I tobacco use contribute to the cause of death?  ] Yes 2 □ No 3 □ Probably 4 □ Unknow				
ecords,	neen hould	Completed														
စ္		du									24a. Was ar autopsy	, I	prior to	utopsy findings a completion of ca	available ause of	
=	pag	Ö									perform 1 ☐ Yes 2		death? 1 ☐ Yes	2 □ No		
Vitai	Physician: The is this certificete ha ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital				1000		of Death	Check only one	)				
6	S (7) T	2	1 ☐ Yes 2 ☑ No		Inpatient	2 ER/Ou		□ DOA Othe	4   14013		e 5½ Reside			icify)		
	fe fe	0	27. Manner of Death t ☑Natural 5 ☐ Pending		nth, Day Ye		Time of njury	28c. Injury Work			8d. Describe ho	w injury	occurred			
<u>s</u>	Attending Phy ir death. ector: After thi by the funeral o	Icat	2 Accident investigation 3 Suicide 6 Could not	ne	a of laive.	At home to			′es 2 □ N		9f Lagation (Ct	(Character Market - Charles - All -				
UNISION	or At after of Direct in by	Certification:	286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								Bf. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying P	hysician: To th	e best of m	y knowledge	e, death occ	curred at the time	e, date and	place, ar	nd due to the ca	use(s) a	and manner as	s stated.		
	thin 24 thin 24 the F mplete	Medical	(Check only 2 ☐ Medical Example)  29b. Signature and title of certifler →	and mai	nner stated.	auon an	wor investi	29c. License		1 OCCULTO				h, Day, Year)		
	N I S		Sol. Signature and this or certifier	Thank	15					MR	3 7		_			
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	<u></u>		d. Meded became her amende	completed car	Medi	cal 23a)	nter	Drive,	#300,	Roc	kville,	MD	20850			
	Sta Registr		31. Date filed (Month, Day, Year)	2006	Registrar's	Signature	Loss	w								

			Sta 1-Angle 31, perDPS, MoCo	ate of Maryland /	Department of Heal  Certificate of Dea		ene2006 27172
	Physici /Medio		Decedent's Narje (First, Middle, Last)	Da	er	2. Date of Death Month	Sar ( AM
	Examin Funeral Director	er	4a. Facility Name (If not institution, give street  SUBURBAN HOSPITAL  5. Social Security Number  577-10-6400  6. Sex	7. Age (In yrs. last I	4b. City, Town, or Loca  BETHES  birthday)   If Under 1 Year   If Under 1 Year   Hollow  Yrs.   Months   Days   Hollow	SDA nder 24 Hrs. 8. Date of Birth	
	anyland ahow		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Location		10d. Inside City Limits
	deeth with the Maryland ms 23s or 28s-f show f must be notilised at	Director	MARYLAND MONTGOMERY  10e. Street and Number		SILVER SPRING 10f. Zip Code	100	1 ☐ Yes 2 🕅 No  I. Citizen of What Country?
	eth wit	ralD	8201 16TH STREET, #913		2091		U.S.A.
036	ours after dee ral', or Items Examiner ma	by Funeral	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? ]Yes 2 X No Yes, Give ear or Dates;	_	c Origin? (Specify Yes or No- xican, Puerto Rican, etc.) acify:	14. Race - American Indian, Black, White, etc.  Specify:  WHITE
altimore, Maryland 21215-0036	should be filed within 72 hours after nd Mental Hygiene. I marked other then "natural", or Ite umatic event. Ite Medical Examina	Completed		pleted) 16 billege (1-4or 5+)	ia. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) HOMEMAKER	most of working	b. Kind of Business/Industry
1 1 2	e filed al Hygi I other vent.	Be Co	17. Father's Name (First, Middle, Last)			Mother's Name (First, Middle, Ma	OWN HOME iden Sumame)
<u> </u>	hould b d Ment marked matic e	101	MORRIS FOGEL  19a. Informant's Name/Relationship (Type, Pr	rintl 16	9b. Mailing Address (Street and No	FANNY FROMIW	
Ra	s 1 and 2 should be filed withir of Health and Mental Hygiene. Item 27 ie marked other than other traumatic event. Ite Me		MRS. NANCY L. KRAKOWER - D		9405 BLACKWELL ROAD,		
imore	permit. Pages 1. Department of He Important: if Iten any injury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	ar irom State	of Disposition (Name of tery, crematory or other place) SRAEL CEMETERY		c. Location - City or Town, State
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Las see	denton	22. Name and Address of F	HINES-KINATIDI	FUNERAL HOME, INC SPRING, MARYLAND 20904
9	Physician /Medical Examiner burial-transit the purial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequence	on: Heart hul Heart	Nesi Diseace	Approximate liveryal Between Obsel and Death Obsel and Death
06 1004 Here 8/1/61 s, P.O. Box 68760	that the death certified by the attending detached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	eart I. 23ə. Did tobac	23d. Date of delivery Month Day Year		
ords	w recuires been sign should be		- PALE	MACZ	NO TO	1 ☐ Yes	2 No 3 Probably 4 Dinknown
Be Rec	The law ate has to bage 2 s	Completed		ON CA	PCEI	24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No 1 \( \text{Yes} \) 2 \( \text{No} \) No
ies, Rac Division of Vit	ing Phys After this uneral di	cation: To Be	2 Accident investigation	I Impatient 25 EH/C	Other	Place of Death   Check only one  Nursing Home 5   Residence 28d. Describe how 2   No	
Divis	spitel or Attending ours after death. Persi Director: After filled in by the funer	Certification:	4 Homicide	e. Place of Injury - At home, building, etc. (Specify)		City or Town, S	
3	To the Hospitel or Attend within 24 hours after death To the Funeral Director: / completely filled in by the fi	Medical	(Check prev 2 Medical Examiner: O	To the best of my knowled, in the basis of examination and manner stated.	ge death senured at the time datend/or investigation, in my opinion,  29c. License numb	death occurred at the time, date	and place, and due to the cause(s)  Date signed (Month, Day, Year)
	(0	İ	flough	ed cause of death (Item 23a	1025	085	8/7/00
	Sta Registr		31. Date filed (Month, Day, Yell)	32. Registrar's Signature	5. Sparle	11/4 3/	110000

State of Maryland / Department of Health and Mental Hygiene 2006For State Registra Certificate of Death Reg. No 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Tran August 9, 2006 1:16 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Arcola Health & Rehab. Center Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖺 F Yrs. 586-44-6919 85 Director Oct. 20, 1920 Vietnam Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Silver Spring Directo Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2606 Belle Crest Lane 20906 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify:Asian ۵ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental H is marked of Chanh Ngoc Tran Chac Thi Nguyen 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any Injury or other traum Kimhoan N. Ngo/ Daughter 2606 Belle Crest Lane, Silver Spring, MD 20906 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Aug. 14, 1 Burial 2 □ Cremation 3 □ Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2006 Rockville, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility.
Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 Limes 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Acute Myocardial Infarction 10 Days /Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine signed by the ettending physiclen and debe detached for use as the burial-transit be executed End-Stage Anuria due to Chronic Ronal Pailure that initiated events Few Months resulting in death) Last Due to (or as a consequence of) Vital Records, P.O. Box 68760 Physician/Medical Pulmonary Fibrosis Several Years 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Hypertension, Diabetes 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate hes al director, page 2 autopsy performed? 1 Tes 3√√No After this certification, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: / 3 \ Suicide 6 ☐ Could not be 28l. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide or A To the Hospital within 24 hours a To the Funeral D lilled 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23429 Hellen August 10, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ton Tat Chieu. M.D. 7505 New Hampshire Avenue, #310, Takoma Park, MD 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 11 2006

Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Benedicte Tchenang 2006 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Benedicte Tchenang 0335 hrs Medical Examiner August 6, 2006 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Takoma Park 6800 blk. New Hampshire Ave If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Davs oreign Cameroon 577-41-6442 Director Dec.3,1953 52 M 2X F Usual Residence of Deceden 10d Inside City Limits 10c. City. Town or Location 10a. State 10b. County Washington, D.C. 1 X Yes 2 No 28a-f show permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Bygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once. irector 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6101 16th Street N.W. #311 20011 Cameroon 靣 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married Yes Black 3 X Widowed f Yes, Give Year Specify Divorced 1 Yes 2 X No specify: ð or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Complet Baltimore, MD 21215-0036 Housekeepper 12 Hotel 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marcus Zuijeu Victorine Njapoum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 2000 1 1 19a. Informant's Name/Relationship (Type, Print) 2 6101 16th Street N.W. #311 Wash., D.C. Flaubert Nkuikam/Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Bagante, Cameroon Bagante, Cameroon Family Cemetery 8/24/06 Other Donation 5 FILTPACTS RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 rice Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery phy the 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months?

Pregnant at time of death Other (Specify Yes 2 V No 9 Unknown 9 Unknown

23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 V No 3 Probably 4 Unknown 24a Was an 24b Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 2 No 26 Place of Death (Check only one) 25. Was case referred to medica examiner? Other 1 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 1 V Yes 2 27. Manner of Death 28b. Time of Injury 28c. Injury at Work' 28d. Describe how injury occurred Pedestrian struck by auto 0325 hrs

28a. Date of Injury (Month, Day Year) Aug 6, 2006 Pending Yes 2 V No 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 6800 blk. New Hampshire Ave., Takoma , MD (Specify) Major Road / Highway Homicide

29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E

August 7, 2006

30. Name and address of person who completed cause of death (Item 23a)

Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month Dat Gea) State 2006

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Completed

Be

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Certification:

Medical

certificate has

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After

e Funeral Director: /

To the I

within 24 hours after death.

Hospital or Attending Physician:

State of Maryland / Department of Health and Mental Hygien 2006

State Registra AMEND#31, perDPS, McCo Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 30 **Physician** Augus 2006 SIDNEY D. TALMUD /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S DOCTORS' COMMUNITY HOSPITAL **LANHAM** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months 1 X M 2 □ F Yrs. PENNSYLVANIA JANUARY 26, 1939 Director 207-30-5312 67 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other then 'natural', or iteme 23a or 28a-f show amy inury or other traumatic event, Ira Madical Examinar must be notified at once. 1 ☐ Yes 2 🖾 No Director PRINCE GEORGE'S SILVER SPRING MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 3156 GRACEFIELD ROAD, APT 112 20904 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 🗓 Yes 2 🗍 No If Yes, Give Year or Dates: 1958 **- 1**962 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify Completed by WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) EMPLOYEE RELATIONS SPECIALIST USDA 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle, Last) Be 2 ELEANOR HERTZ LOUIS TALMUD 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3156 GRACEFIELD ROAD, APT 112, SILVER SPRING, MARYLAND 20904 DOROTHY TALMUD - WIFE 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or o MARYLAND NATIONAL other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) AUGUST 11,2006 LAUREL, MARYLAND MEMORIAL PARK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC Myelin 1. 1 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) attending physicien a for use as the burial-Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) Vital Records, P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the upperlying cause given in Part I. by Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performer 1 Yes 2 No 25. Was case referred to medical examiner? filled in by the funeral director 26. Place of Death (Check only one) Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Impatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Division of After or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funerel Director. 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 18 s of person ino completed cause of death (Item 23a) (Type, Print) 81 Madehada, MD 32. Registrar's Signature 31. Date filed (Mont) Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Charles Edward Wivell, Sr. August 22, 2006 10:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Smithsburg 49 East Water Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1**X**) M 2□ F Yrs. March 5, 1930 76 Director 217-28-2186 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r then "netural", or itema 23a or 28a-f ehow tre Medigal Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Washington Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21783 U.S.A. 49 East Water Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X1 Yes 2 □ No 1951 – If Yes, Give Year or Dates: 1954 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2X Married 1 ☐ Yes 2X No Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Agent Insurance 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Menial Hy Impordent: if Nem 27 is marked oth any injury or other treumatic event 2008. Helen L. Guise Roy J. Wivell, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 49 East Water Street Smithsburg, Maryland 21783 Mary I. Wivell (Wife) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Mt. St. Mary S August 25, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Emmitsburg, Maryland 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, MD 21783 DAVIS Lee Point. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ None 1 Yes No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes Solono 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home SE Residence 6 Other (Specify) 1 ☐ Yes € No this 28c. injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospitel or Attending 94 hours after death. **◆** Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Baltimore, Maryland 21215-0036

Box 68760

P.O. 1

Records,

Division of Vital

State Registrar 31. Date filed (Month, Day, Year) AUG 2 3 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

W. E. Kutzera



Ave

29d. Date signed (Month, Day, Year)

Hagerstown MD 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 006

Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) AUGUST 10, 2006 **Physician** KATHERINE LENORE WILDMAN 11:30 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner LAUREL REGIONAL HOSPITAL PRINCE GEORGE'S LAUREL. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
JULY 16, 1938 WASHINGTON D.C. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 🏋 F Yrs 68 219-34-9972 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28e-f show r than "natural", or iteme 23s or 28e-f ehov the Medical Examiner must be notified at 1 K Yes 2 □ No MARYLAND PRINCE GEORGE'S BOWIE Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 8610 MAPLE AVENUE U.S.A. 20720 death 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritaf Status hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 Marned Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry e filed within 72 has Hygiene. 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Efementary/Secondary (0-12) Coltege (1-4or 5+) LAW LAW REPORTER 12 other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill I Health and Mental H tem 27 ie marked oth JAMES EDWARD WILDMAN, JR. KATHERINE VERA SWEENEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health ar
Important: If item 27 ie
eny injury or other trau JOHN M. WHALEN / BROTHER 1120 QUAIL CIRCLE, DESTIN, FLORIDA 32541 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition HOLY TRINITY EPISCOPAL 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8/15/2006 BOWIE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) CHURCH CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME, 16000 ANNAPOLIS ROAD, BOWIE, MARYLAND 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) POLYMICROBIAL SEPTICEMIA 2-3 WKS **Physician** /Medical Due to (or as a consequence of) Examiner CORONARY ARTERY DISEASE 3 WKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ASPIRATION PNEUMONIA 2-3 WKS ettending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year in the past 12 months? 1 ☐ Yes 2 XXIII 4 Pregnant at time of death 5 Other (specify) ed by tha e 9 Unknown 9 Unknown signed t Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 INFECTED SACRAL DECUBITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been sig Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2√2 No 24a. Was an DYSPHAGIA 5/8 PEG certificate has b autopsy performed? DEMENTIA 1 ☐ Yes 2 🔀 No Hospital or Attending Physician: aftar death.

Director: After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No 28b. Time of fnjury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 24 hours aftar de Funerel Directo etely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

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State Registrar

(Check only

29b. Signature and title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

ATTERDING

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MICHAEL BAAKO, MD, LAUREL REGIONAL HOSPITAL, 7300 VAN DUSEN RD., LAUREL, MD 20707

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Do057216

29d. Date signed (Month, Dey, Year)

AUG 10, 2-006

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9.00 C

		ŕ	For State Of Mary t	Cer	riment of Health and tificate of Death		Reg. No.	27178					
.0	Physici	an .	Decedent's Name (First, Middle, Last)			2. Date of Dea Month	Day Year	3. Time of Death					
8	/Medic		DONALD JAMES  4a. Fecility Name (If not institution, give street and number)	WALTERS	4b. City, Town, or Location of Dea	AUG.	6 2006 4c. County of Dea	5:20 P <sup>M</sup>					
	Examin	eı	MEMORIAL HOSPITAL AT EASTON	4	EASTON		TALBOT						
	Funeral		1 <b>W</b> M 2□ F	yrs. last birthday)	If Under 1 Year If Under 24 Hr Months Days Hours Mir		h y, Year) 9. Bii	thplace (State or Foreign ountry)					
	Director		216-20-3324 79 Usual Residence of Decedent	Yrs.		MAR. 2	7,1927 M	ARYLAND					
	yland			c. City, Town or Loc	ation			10d. Inside City Limits					
	e Mar	ctor	MD TALBOT	EASTO	N			1 ☐ Yes 2 <b>X</b> No					
	vith th	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	ountry?					
	eath v	erai	33047 LOVE DAYS LANE  11. Marital Status  12. Was Decedent Ever in	in II S 13 W	21601	Specify Ves or No.	USA 14. Race - Am	orican Indian					
က	within 72 hours after death with the Maryland ene. than "neturel", or iteme 23e or 28e-f ehow fre Madical Exertiret must be notified at	Funerai	Armed Forces?  1 □ Never Married 2 ★ Married 1 ★ Yes 2 □ No		/as Decedent of Hispanic Origin? ( Yes, specify Cuban, Mexican, Pue	nto Rican, etc.)	Black, Whi	te, etc.					
8	ural', c	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates: 194	45–1947	☐ Yes 2 X No Specify:		Specify:	WHITE					
21215-0036	n 72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupation and of work done during most of wo O NOT use retired)	orking	16b. Kind of Business	/Industry					
72	l withii iene. r than	ошо	Elementary/Secondary (0-12) College (1-4or 5+)  12 2		S MANAGER		MUSIC						
<u>p</u>	e filed al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)	- Otalia		me (First, Middle,	Maiden Sumame)						
Sla	Menti Menti Marked	70	WARREN C. WALTERS				DUNUS						
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic avant, it is Madical Examinat must be notified at once.		19a. Informant's Name/Relationship (Type, Print)  W. GLORIA WALTERS/ WIFE		Address (Street and Number or F			Zip Code)					
	s 1 an f Heal itam 2 other			Ob. Place of Dispos	ition (Name of	Date	20c. Location - City or	Town, State					
E	Page nent o ant: ff ury or		1   Burial 2 □ Cremation 3 □ Removal from State  Donation 5 □ Other (Specify)		ETERAN CEMETERY	8-10-20	06 HURLO	CK, MD					
Baltimore,	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee	3.33.3	Name and Address of Facility LLOWS, HELFENBEIN	ANUNA 3 L	M FIINFRAT	номе ра					
	0 5 5 0 A		Dosph m. Oshowski C.F.S.F.	20	O S. HARRISON ST	C., EASTO	N, MD 2160	1					
1000	3		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Chronic Lymphourfic Leukenia  Due to (or as a consequence of):										
	Physician /Medical												
	Examiner			130400000017.	•								
100	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of):									
	and and I-trans	Examiner											
68760,	eath certificate be executed attending physician and for use as the burial-transit												
		_	d										
Box	th cer tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ F	23d. Date of de									
P.O.	that the death cer ed by the attendir detached for use	Physician/N	1 Yes 2 No 4 Pregnant at time 9 Unknown 9 Unknown	Month	ith Day Year								
۳.	The law requires that the death cer ate hes been signed by the attendir page 2 should be detached for use		Part If. Other significant conditions contributing to death but not	t resulting in the un-	derlying cause given in Part I.	23e. Did to	bacco use contribute to	o the cause of death?					
rds	w requires been sign should be	ed by	hemolytic arami	a		1 🗆 Y	es 2 PNo 3 □ P	robably 4 \(\sum \)Unknown					
Division of Vital Records,	ie law requ hes been je 2 shouli	Completed	coronary artery	24b. Were autopsy findings available prior to completion of cause of									
<u> </u>	ysician: The is certificate he director, page	Соп	0				med? death?	2 □ No					
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ō	g Physer this eral di	n: 70	27. Manuar of Death 28a. Date of Injury	2 ER/Outpatient 28b. Time of	28c. Injury at		lence 6 Other (Speciow injury occurred	cily)					
<u>o</u>	Attending or death.	atio	1 Natural 5 Pending (Month, Day Year) fnjury Work? 2 Accident investigation M 1 Yes 2 No										
<u> </u>	l or Attendater deatl	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Fig. City or Town, State)										
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	To the Hospitel or Attanding Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier  (Check only one)  12 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.	mination and/or inve	occurred at the time, date and placestigation, in my opinion, death occ	urred at the time, o	ause(s) and manner a: date and place, and du	s stated. e to the cause(s)					
	To the within 2 To the complet	M	29b. Signature and title of sertifier		29c. License number		29d. Date signed (Mont						
)	,		· Un C. ( vinte	ريد ر-	64043		Figure 6	, 2006					
1.	57-VA		30. Name and address of person who completed cause of death (	(Item 23a) (Type, P	rint). St. FA	(Dr.	Figure 6	7/					
1	Sta	te	31. Date filed (Month, Day, Year) 32 egistrar's Si	ignature	chighn St. EA.	3 (0,0)	0 216	~/					
	Registr		AUG 0 8 2006	All Alex	- 18 c								

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ginald Lee Wil		State of Maryland / Department 1- For State Registrar  State of Maryland / Department  Certificate			id Meni	tal Hyg		eg No.	200	06	2717	
Physicia edical Examir	n/ ier	1. Decedent's Name (First, Middle,Last)  Reginald Lee Wilson			_		Date of Dear Month August 5,	Day 2006	Year	150	e of Death 32 hrs	
		4a Facility Name (if not institution, give street and number) Route 298 at Black's Station Road	4	Kennedyvil		of Death			County of De ent	ath		
Funeral Director		210 , 0 312.	) Yrs.	If Under 1 Year Months Day	_	Min.	8. Date of Bir		For	eign	(State or aryland	
ith the Maryland 23a or 28a-f show any notified at once.	tor	Usual Residence of Decedent  10a. State	catio	on 10f. Zip Code				0-01	())	1	side City Limits Yes 2 X No	
the Man a or 28a iffed at	Director	10e. Street and Number 13295 Clark Road	21667				l'	US	en of What Co ${f A}$	ountry?		
death w	Funeral	11. Marital Status 1 Never Married 2 Married Arned Forces? 1 Yes 2 No	If Ye	s Decedent of Hi es, specify Cuba	n, Mexican				4 Race - Am White, etc.		an, Black,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Menial Hygione Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examinger	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	dent g ma	t's Usual Occupa ost of working life	ation (Give e. DO NOT			16b. Kr	nd of Busines	s/Industry		
15-003 filed within al Hygiene ed other th	e Comp	17 Father's Name (First, Middle, Last)	Maintenance  18 Mother's Name (First, Middle Grace L. Co									
212 hould be and Menta is mark	<b>∞</b>				et and Num	ber or Ru	ral Route Nun	nber, City	r, City or Town, State, Zip Code)			
e, MC 1 and 2 sl Health ar item 27	-	20a. Method of Disposition 20b. Place of Disposition	posi				, Mary		21667 ocation - City		State	
Pages Pages ment of tant: If or other		Burial 2 Cremation 3 Removal from State crematory or Colemans	s 1	U.M.C.					leman,	-	land	
Ball permit Depart Impor				ennie Si ad 298,						:0		
Physician /Medical Examiner		Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	er th	ne mode of dying	), such as c	ardiac or r	espiratory arr	est, shoc	k, or heart		oximate Interval een Onset and Death	
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Vital Rec ysician: The his certificate director, page	o Be	25 Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpati	ient		Other	-		Residen	ce 6 🗸 Ott	ner Scene		
_ # _ ^ 4	-1	27. Manner of Death  1 Natural 5 Pending Aug 5, 2006  2 Accident Investigation 12			ury at Work Yes 2	חו	8d. Describe river auto					
Division To the Hospital or Atteudi within 24 hours after death To the Funeral Director: /	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s	stree	et, factory, office	building, et		or Town, S	state)			e Number, City Kennedyville,	
To the Hospital within 24 hours. To the Funeral	Medical	29a. Certifier (Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or invest and manner stated.									(s)	
E S E S	Me	29b. Signature and title of certifier  Way Tell  And Thailine States.			.M.E.	<del>-</del>	-	1	ate signed (finist 6, 2006		,Year)	
15+1VA		30 Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111	1 Pe	enn Street, E	Baltimore	, MD 2	1201					
	ate	31. Date filed (Month AUG at 0 9 2006 32. Recommendation of the state	B	La Ri								

DHMH 17 Rev 1/2001 OCME 2006

		•	For State Registrar	State of Ma	aryland /	Depa <i>Cer</i>	irtment of H <i>tificate of L</i>	lealth and N Death	Mental Hy	giene Reg. No	2006	27180
- 1	Dhusisi	<b>1</b>	1. Decedent's Name (First, Middle, La	ast)					2. Date of De	aath Da	y Year	3. Time of Death
	Physicia /Medic		Thomas	Otha		Wils	on,Jr.		08	03	2000	9:45 PM
	Examin		4a. Facility Name (If not institution, gi			,	0 0 %	Location of Death		40	. County of Death	
			5. Social Security Number 6.		e (In yrs. last		If Under 1 Year	اf Under 24 Hrs.	9 Date of Bi	eth.	O Bist	place (State of Foreign
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	death with the Maryland ms 23a or 28a-f ehow rmest terrolified at	_	10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits 1
	Ba-f	Director	Maryland		Balti	lmore						
	with th	ā	10e. Street and Number				10f. Zip Code				tizen of What Cor	intry?
	death w	era	6672 Pioneer	12. Was Decedent	Ever in U.S.	13.1	Vas Decedent of H		pecify Yes or No		JSA 14. Race - Amer	ican Indian
36	within 72 hours after d ane then "natural", or iten na Modical Examinar	by Funeral	1 Never Married 2 Married 3 Widowed 4 ★Divorced	Armed Forces?  1  Yes 2 7			Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2☐ No	in, Mexican, Puerto Specify:	Rican, etc.)		Black, White Specify:	, etc.
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Maryland 21215-0036	be filed within 72 hutal Hygiene. d other then "natuevent, me Medicel	Completed	(Specify only highest gi	rade completed) College (1-4or 5	i+)	(Give life. L	kind of work done of OO NOT use retired	during most of world)	king			
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yla	should be nd Mental marked o	ပို	Thomas Otha	Wilson,Sr.				Julia	K. Whe	eler	2	
lar	2 6 8 2		19a. Informant's Name/Relationship				g Address (Street a					p Code)
	1 and 2 Health em 27 I		Loleta Wilson	Lan / Daug	hter		2 Edisto		timore,			
ore	f of H ff ite or oti		20a. Method of Disposition  1    Burial 2   □ Cremation 3 i	☐Removal from State	ceme	etery, cren	sition (Name of natory or other plac		Date	20c. L	ocation - City or I	own, State
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Baltimore,	permit. Pages 1 an Department of Heat Important: if item 2 eny injury or other once.		21. Signature of Funeral Service Lice	ensee		22	Name and Address Bennie Sn 426 Dove	ss of Facility nithFuner	al_Home			
	-35 -6	-	23a Part Friesthe disease or cor	nolications that caused	the death D						ryland	Approximate
			23a. Part 1. Embed is lease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Interval Between Onset and Death
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Ś	res tha igned be del	þ	Part II. Other significant conditions	contributing to death b	ut not resultin	g in the ui	nderlying cause give	en in Part I.				the cause of death?
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ec	e law has b	nple	whitestul orices	Blechi	ng.				24a. Was	psy	24b. Were au	opsy findings available ompletion of cause of
E .	: The f	ပ္ပ							1 ☐ Yes	ormed?	death?	2 No
Vita	ysicien: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea				
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Division of Vital Records,	ding Phy h. After thi funeral	tlon	1 atural 5 Pending	28a. Date of Inju (Month, Da	y Year)	Injury	Worl	yat k? Yes 2 □ No	200. Describe	now inju	ry occurred	
Si	deatl deatl ctor: y the	lica	3 Suicide 6 Could not	be 00 51 (1.5	urv - At home	farm. str	eet, factory, office	103 2 110	28I. Location	Street ar	nd Number or Ru	ral Route Number,
$\frac{1}{2}$	after after Dire	Certification:	4  Homicide	building, et	c. (Specify)	, , , , , , , , , , , , , , , , , , , ,	,,		City or To	wn, State	Θ)	
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificete has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier 1 - Littiying F (Check only one) 2 Medical Exe	hysician. To the best iminer: On the basis of and manner sta	f examination	dga, daatl and/or in	roccurred at the time vestigation, in my o	ne, date and place pinion, death occu	, and use to the rred at the time,	cause(s date an	) and manner as d place, and due	stateu. to the cause(s)
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			30. Name and address of person who	completed cause of d	leath (Item 23	a) (Type.	Print)	/		-/	1	
(	(A)		JADEEP HINGE		601 L	oc ir	RAUIZIO	BLUD.	BALT	7.11	WRE 1	UN -24239
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DHMH 17 Rev 1/2001

Thomas wilson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death AUG. 11, 2006 **Physician** 4:00 P M WOOD GATL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CHARLES LA PLATA CHARLES COUNTY NURSING & REHAB CNTR. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB 13, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 💢 F OHIO Yrs. 579-22-4636 88 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🗓 No Director PRINCE GEORGE'S FT. WASHINGTON MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. other than "naturel", or iteme 23a or rent, tra Macical Exercine count be death with 20744-2830 UNITED STATES 1307 ADAMS DRIVE Completed by Funeral permit. Peges 1 and 2 should be filed within 72 hours after deat Department of Heelth and Mental Hygiene. importent: If item 27 is marked other than "near any injury or other traumetts." 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify. 3X Widowed 4 ☐ Divorced WHITE 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL DIETICIAN/NUTRICIANIST 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MARGARET BLANCHE MILLER JAMES WILLIAM SMITH, SR. ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIRGINIA W. BURCH - DAUGHTER 30670 BIG HORN COURT, CHARLOTTE HALL, MD 20622 20a. Method of Disposition

Washial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State AUGUST 18, 2006 WOODLAND CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) ASHLAND, VIRGINIA 21. Signature of Funeral Service Licensee M00053 22. Name and Address of Facility HUNNT FUNERAL HOME, P.O.BOX 156, WALDORF, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** Em Physema disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine physicien and the burial-transit Hospital or Attending Physician: The law requires thet the deeth certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No þ Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 12 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 3 No 25. Was case referred to medical 26. Place of Death Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this After th funeral 27. Manner of Math 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural Japiter James Africator: Africato 5 Pending 1 ☐ Yes 2 ☐ No investigation in 24 hous. tha Funeral Dires. 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00052919 arrens AUGUST 14, 2006 kimes 30. Name and a draws of person who completed cause of death I tem 23a) (Type, Print) JAMES HARRING, MD., 102 CENTENNIAL ST., SUITE 102, LA PLATA, MD 20646

Registrar

Box 68760,

P.O. 1

Records,

Division of Vital

32. Registrar's Signature

AUG 1 5 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 1:00 PM August 8, 2006 Sadie C. Wheeler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 302 Dunnville Place Upper Marlboro Prince Georges 8. Date of Birth (Month, Day, Ye. Nov. 19, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year) Months Days Hours 1 M 20 F 1920 280-22-5933 Georgia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28e-1 show r than "natural", or Items 23a or 28e-f shov the Medical Examinar must be notified at 1 Yes 2 No Prince Georges Maryland Upper Marlboro Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 302 Dunnville Place 20774 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced African American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "na eny fing yo or other treumatic event, the Mental once. (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Division Chief Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Clarke Armanda Beale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James B. Wheeler (husband) 302 Dunnville Pl., Upper Marlboro, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 8/14/06 | Silver Spring, MD 4 □Donation 5 □Other (Specify) 9 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Figneral Service Licensee nolse 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7400 Georgia Ave. N.W., Wash. D.C. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 45Phaa /Medical onsequence of): Dementia Examiner heimer 15 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 No Month Dav 4 Pregnant at time of death 5 Other (specify) ed by the e After this certificete hes been signed I funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours efter deat To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 🗽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of perutie 29c. License number D0053337 8/10/06

State Registrar Dorothy

31. Date filed (Month, Day, Year)

AUG 1 1 2006

Seay, mD

32. Registrar's Signature It Sparks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Suite 205 Silver Spring, Md 2090)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 106 Amend item 1- State Amend item 45 per Fh/wichd/8-15-06/dls Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Patricia ialigiti Harriett 08 2000 2206 0 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homico Medical RIVIU 31418b4111 REGIONAL If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 577-36-6002 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1 ☐ M 2 🕱 F Director 2-18-1937 Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ehow word Item 27 ie marked other then "naturel", or Iteme 23a or 28e-f ebov other traumatic event, the Modical Examinar must be incitified at 1 No 2 No Director Accomach New hurch 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a3415 Evergreen Drive , S. H 33 **a a** 8 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 No 1 Never Married 2 Married 1 ☐ Yes more, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Specify: White 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Specialist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fi Be Russell Baffert ၀ Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 20b. Pla Rosemary 3019 , VA ralls Lone Church 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Important: If it eny injury or o once. 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State 8/14/06 Occo hannock Cromatery xmore, UA 4 ☐ Donation 5 ☐ Other (Specify) VA 23336 21. Signature of Funeral Service Licenses 22. Name and Address of Ficility Imanda Chincoteagr Salver Funeral Home 6327 Church St Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OUXA Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Exam resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the e 9☐ Unknown 9 □ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Ses 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 Tyes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) Medical Certification; To 1 Yes 1 ☐ Inpatient 2 TNo 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 1 ■ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation deeth. 1 Yes 2 No Director: / 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct

Completely filled in by t filled in by 4 | Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zew Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 8/11/06 1450 49) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E Carroll St. SAlisbury hris Swyder 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 4 2006 Registrar Goarle

Patricia

Kaitis

State of Maryland / Department of Health and Mental Hygiene 2006 1 = For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Barbra 4:35 PM yres 27 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BelAir Medical Center Upper Chesapeake Harford If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 216-54-4721 Yrs. December 29, 1950 Mary land Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow the Madical Examiner must be notified at 1 ☐ Yes 2 No Harford Edgewood Directo Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21040 1620 Swallowcrest Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or iteme 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 37 CC 035 Imore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OwnHome Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental is marked c Gordon W. Jewel Livingston

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) pe mit. Pages 1 and 2: Department of Health at Im. ortant: If item 27 ie an, injury or other trau 1620 Swallowcrest Sharon Edgewood Drive MD 21040 Ayres / Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Renistry August 28,2006 Hanover 4 2 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Services 22. Name and Address of Facility Anatomy Eifts Registry 7522 Connelley Drive Suite P. Hanguer MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Archythmia disease or condition resulting in death) 2 hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its and a second cause). Due to (or as a consequence of) After this certificete has been signed by the attending physiclen end funeral director, page 2 should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Ayres Barbare M. D. Box 6876 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Non small cell 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 文 Únknown 40 600.00 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an 21 Physe na 25. Was calle referred to medical Dia bed 1□ Yes 2XNo 26. Place of Death Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA ate of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Tes 2 No М 2 Accident investigation within 24 hours after death To the Funerel Director; completely filled in by the I 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) effrey I hompson 500 Upper Chosapake Dr. Beldry MD 2/014 A-32. Registrar's Signature 31. Date filed (Month, Day, Year) Cost Registrår AUG 2 9 2006

		For State Registrar  1. Decedent's Name (First, Middle, Last)	State of Maryland		tificat			ilu ivi	2. Date of Dea	teg. No.		3. Time of D	
Physici /Medic	an al	SHIELA J	APPLESTEIN	/			7.50	(5)	AUGUST		rat	1240	P
Examin	C:	4a. Facility Name (If not institution, give s HOWARD COUNTY GEN	ERAL HOSPITAL				COLUI	MBIA				WARD	
Funeral Director		5. Social Security Number 6. Security Number 213-32-7325		t birthday) Yrs.	If Under Months	Days	Hours	Min.	8. Date of Birth 06/04/	1932	9. Birt	hplace (State or MD	Fore
show sign		10a. State 10b. County  MD BALTIMO		Town or Loc		ILLS						10d. Inside City	-
or 28a-	Direct	10e. Street and Number		ONZI	10f. Zip		2111	7		10g. Citiz	zen of What Co	untry? USA	
ene. than 'naturel', or items 23e or 28e-f show 'ya Medical Examiner must be notified at	by Funeral Director	9805 MIDDLE MILL  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	DRIVE  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Vas Decer Yes, sper				cify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc.  Specify: WHITE		
Hygiene. kher than "naturel", or Items 23e or 28e-f show ent, Ite Medical Examinet must be notified at	Completed to	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Deced (Give I lite. D	kind of wo OO NOT u	rk done di	uring most	of workin	ng		Kind of Business/Industry EECH PATHOLOGIS		т
ed othe	To Be C	17. Father's Name (First, Middle, Last) HARRY	-	ASHM	IAN		18. Mothe RO		(First, Middle.	Maiden	Sumame)	CUSHN	ΙΕΙ
Department of Health and Mer Important: If item 27 Is marke eny injury or other traumatic once.		LAWRENCE APPLESTE  20a. Method of Disposition  1 1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signal for Influence Service Linear	emoval from State 20b. Pla	ce of Dispos netery, crem ES MON	sition (Nar natory or d ITEFII . Name ar	ne of other place ORE O	EM.	08/2 SOI	ate 7/2006 L LEVIN	20c. Lo H SON	cation - City or IALETHOF	RPE, MD	
xa Ale hes been signed by the ettending physician and signed by the ettending physician and sage 2 should be detached for use as the burial-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque  Due to (or as a conseque  Due to (or as a conseque	ence of):	41211	7H C	CIFICE					_ 1 yea x	
the ettending postering the	Physician/Medic										23d. Date of del Month		
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this certifica	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No	fospital: 1 Nincatient 2□E	R/Outpatien	t 3 D	Othe	_		<i>(Check only o</i> ne 5 ☐ Resid		S □Other (Spe	cify)	
Aftar fune	Certification:	27. Manner of Death  1 Natural 2 Accident 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hon	28b. Time of Injury	М		at ? ∕es 2 □	No		Street an	d Number or Ri	ural Route Numb	ber.
within 24 hours after deat To the Funeral Director: completely filled in by the	Medical Certif	29a. Certifier 1 Certifying Phy	building, etc. (Specify) sician: To the best of my know ner: On the basis of examination and manner stated.	ledge, death	occurred	at the tim	e, date an inion, dea	d place, a	City or Tow and due to the ed at the time,	cause(s)	and manner as	s stated. e to the cause(s)	
within To the comple	Me	29b. Signature and title of certifier  Midneys How	111×			c. License	25110			iAn	e signed (Mont	4 300	6_
0		30. Name and address of person who co	ompleted cause of death (Item ELAKUS 11065) 32 Registrar's Signatu	23a) (Type, Li T T L E	Print)	uxei	17 P	Fi, 1	Clambi	1	MARY /41	71) 2104	ili

State of Maryland / Department of Health and Mental Hygiene 006 27186 For State Registra 1-Certificate of Death 2. Date of Death edent's Name (First, Middle, Last) Month 26 2006 **Physician** rugust /Medical 4b. City. Town, or Leestion of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. If Under 1 Year Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 F MD Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c City Town or Location 10a. State 28a-f ahow traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo MD Anne Arundel Hanover 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 21076 U.S.A. 7405 Hawkins Drive or Itama 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married White 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced "natural", Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 77 is marked other than "r. College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Agnes Kelly John Jenkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) mit. Pages 1 and 2: partment of Health a portant: If item 27 is y injury or other trau 7405 Hawkins Drive Hanover Maryland 21076 Mr. Charles A. Anderson/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. 2006 20c. Location - City or Town, State Date . 30, 20a. Method of Disposition tX Burial \_ 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Hanover, Maryland Friendship Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature of Fun ral Service # Second Avenue SW Glen Burnie, MD 21061 Approximate Interval Between Onset and Death So not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebro Vascular **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physician Completed by Physician/Medical as the l signed by the attendin be detached for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 🗌 Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this tuneral of 28a. Dite of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Teath

1 X Natural

2 Accident Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. Director: A d in by the fu investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) ipletely filled in by 4 THomicide after within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier MD. person who completed cause of death (Item 23a) (Type, Print) 30 Hogistrar's Signature 31. Date (filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Items 20b, c per fh 8858 8-29-06 vt. State of Maryland / Department of Health and Mental Hygiene 10 6 AMEND ITEM#12,19b per INF of Ceating 12/06, WS Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 1615 Nillis 08 2000 Brown 4c. County of Death N/A 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Medical Center Bulhimore
If Under 1 Year If Under 24 Hrs. University of Manyland 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) V6. Sex 1X M 2□ F 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours Min. 70 224-42-9152 Yrs. 02/17/1936 VIRGINIA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location
BALTIMORE CITY 10b. County N/A MD 1 XYes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21223 USA 2 N. SMALLWOOD ST., APT. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married TOWNS 2 NO If Yes, Give Year or Dates: BLACK 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) KERRI MCGEE CHEMICAL CO. Elementary/Secondary (0-12) 1 1 TH College (1-4or 5+) LABORER 18. Mother's Name (First, Middle, Maiden Sumame)
JEANETTE DURRANT 17. Father's Name (First, Middle, Last) WILLIS BROWN 29 NORTH MADETRA or ST. Route Number, City or Town, State, Zip Code)
7 MCADETRA BALTIMORE, MD 21205 19a. Informant's Name/Relationship (Type, Print) SARAH L. BELL / SISTER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Dispering Countries Lansdowne MILLS, 1 Removal from State 1 Removal from State <del>-8/30</del>/06 4 ☐Donation 5 ☐ Other (Specify) HOME 21207 22. Name and Address of Facility HOWELL FUNERAL HOME 212 Muneral Service Licensee 22. Name and Address of Facility 21. Signature Approximate Interval Between Onset and Death her the disease, or complications that caused the death heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, diat ause (Final Myscarmai Marchion e of condition in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Cher (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? vent lato 3 robably 4 □Unknown 1 ☐ Yes 2 ☐ No Sease essendent 24a. Was an autopsy performed? monavo 1 Y Yes orlisam 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. Records, Division of Vital his death. Director: within 24 hours after To the Funeral Dire

Examiner burial-transit Be Completed by Physician/Medical use as the attending for use as ed by the a 2 Certification: filled in by Medical (

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

or 28a-f show

Director

Completed by Funeral

Be

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if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iten eny Injury or other traumatic event, the Medical Examinal.

Baltimore, Maryland 21215-0036

State

Registrar

THE

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

Baltimore

1441764351-116 779

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 S. Greene Street Meenaghan

31. Date filed (Month, Day, Year)

29a. Certifier (Check only one)



		4	State of Maryland / Department of Health   - State   Certificate of Death		tal Hygier	_ <	2006	27	188	
			1. Decedent's Name (First, Middle, Last)	2. 0	ate of Death		74.53	3. Time of De	eath	
	Physicia	an	Julia P. Bennett		Nonth	Day 26	2006	10:201	AM	
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1 Under 2015 88 Yrs.	s Min. (/	Date of Birth Month, Day, Ye 2 / 29 / 1	ar)	Coun	try)		
	Director		Usual Residence of Decedent	]	2/29/1	911	west	Virg	TIII	
yland	Mot W		10a. State 10b. County 10c. City, Town or Location				10	d. Inside City		
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	tural'		3 ⚠Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education   16a. Decedent's Usual Occupation		166	. Kind of	Business/Ind			
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IMOT Pages	oartment of sortant: If I injury or ££.		1X Burial 2 □ Cremation 3 □ Removal from State   Oaklawn Cemetery	2006			imore			
<b>Saitim</b>	Departi Import any inj once.		21. Signature of Funeral Service Licensee 22. Name and Address of Face Evans Funeral	•	D			ord Rd , MD 2		
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t V	is cer direc	To B	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4	Nursing Home	5 Residence	e 6 🗆	Other (Specify	1)		
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5 5	D P	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	251.	City or Town, S	State)	and or mana	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
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9e Ho	n 24 t	edicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, of and manner stated.	death occurred a	it the time, date	and plac	ce, and due to	the cause(s)		
Tot	within 2 To the	Σ	29b. Signature and title of certifier 29c. License number	per /	29d	. Date sig	ned (Month,	Day, Year)		
	1		/ Klynn   054 /	136	C	18/2	6/06			
15	)		30. Name and a riess of person o completed cause o dath (Item 23a) (Type, Print)		p	111		11 21-	777	
		ate	Dr. Kamlum Auyeung MD. 9000 Franklin Squ 31. Date filed (Morith, Day, Year) 32 Segistrar's Signature	uare Do	ive, ba	ITIM	LOTE 14	IN al	<u>~5/</u>	
\$	Regist	ate trar	29b. Signature and title of certifier  29c. License number of an analysis of person of completed cause of dath (Item 23a) (Type, Print)  29c. License number of a ress of person of completed cause of dath (Item 23a) (Type, Print)  29c. License number of a ress of person of completed cause of dath (Item 23a) (Type, Print)  29c. License number of a ress of person of completed cause of dath (Item 23a) (Type, Print)  29c. License number of a ress of person of completed cause of dath (Item 23a) (Type, Print)  29c. License number of a ress of person of completed cause of dath (Item 23a) (Type, Print)  29c. License number of a ress of person of completed cause of dath (Item 23a) (Type, Print)  29c. License number of a ress of person of completed cause of dath (Item 23a) (Type, Print)  29c. License number of a ress of person of completed cause of dath (Item 23a) (Type, Print)  29c. License number of a ress of person of completed cause of dath (Item 23a) (Type, Print)  29c. License number of a ress of person of completed cause of dath (Item 23a) (Type, Print)  29c. License number of a ress of person of completed cause of dath (Item 23a) (Type, Print)  29c. License number of a ress of person of completed cause of dath (Item 23a) (Type, Print)  29c. License number of a ress of person of completed cause of dath (Item 23a) (Type, Print)							

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 20:40 Ine11 Booker 8 23 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Balto If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2XF Yrs. 213-28-5592 76 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State ehow Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygene.

and the Health and Mental Hygene.

and the transked other then "natural", or Items 23s or 28s-1 e hou and the translation of the Madical Examplations the notified at any or other transatic event, in a Madical Examplation of the notified at 1X Yes 2 No Directo Md N/A Balto 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2848 Oakford Avenue 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: Completed by 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Nurse Private Duty N/A18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Woody Walton ဥ Charlie McClendon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles Allen Booker - Son 796 Cross Street Balto, Md 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of h Important: If It any Injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Vet 8-29-2006 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H 21. Signature of Funeral Service Licenses Edmone 4300 Wabash Avenue Balto, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Breast CANCER ear TASTAT Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the attending physiclen and hed for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day Year 5 Other (specify) signed by the a o 9□ Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? yes 2 No has 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 ER/Outpatient 3□ DOA this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: Injury 1 Natural 5 ☐ Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the e 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 24, 2006 025205 3 who completed cause of ath (Item 23a) (Type, Print) N. Charles St. Balto. Md Z120x Riley BINC 6701 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 2 9 2006

			1 - For State Registrar	State of M	aryland /	Depa <i>Cer</i>	rtment of H tificate of	lealth and l <i>Death</i>	Mental Hy	/giene2	006	27190
			1. Decedent's Name (First, Middle, La	st)					2. Date of D Month		Year	3. Time of Death
	Physici /Medio			Salimot	Bawa	<b>-</b> 02	undele		August	19, 2	006	10:03 A M
	Examir		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, o	or Location of Death	1	4c. Co	unty of Death	
sal invol			Greater Baltimore				Towson	Tutte	· · · · · · · · · · · · · · · · · · ·		imore	
	Funeral		5. Social Security Number 6. S	Sex 7.Ag I□M 2XDF	e (In yrs. last	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D			place (State or Foreign ntry)
5	Director		212-75-8224 Usual Residence of Decedent		40	113.			2-1	6-1966	Nig	eria
CI	land see		10a. State 10b. County		10c. City, To	own or Loc	ation				1	10d. Inside City Limits
12	Man,	ţ	Md	N/A	Balto	)						1 Yes 2 □ No
~ 7	r 28a	rec	10e. Street and Number	MA			10f. Zip Code			10g. Citizen	n of What Cou	ntry?
V.	h witi	O E	5619 Laurelton A	venue			21	214		Nig	geria	
1	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or iteme 23a or 28a-f ehow int, the Medical Examinar must be notitied at	by Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V		dispanic Origin? (Si an, Mexican, Puerto	pecify Yes or N	0- 14.	Race - Americ	
9	after dea or iteme	正	1 ☐ Never Married 2 X Married	1 ☐ Yes 2 🔯	No	1	☐ Yes 2∑ No		o riican, etc.)		Black, White,	
~ S	ure!,	d b	3 Widowed 4 Divorced	1							pecify: B1a	
215-0036	"net	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16	Give /	ent's Usual Occup	oation during most of world)	king		of Business/In	dustry
75	withir ane. then	E D	Elementary/Secondary (0-12) 12th grade	College (1-4or	5+) N/A					Mi:	litary	
VP	filed Hygi ther ant,	ပိ	17. Father's Name (First, Middle, Last		N/A	AL	my Offic	18. Mother's Nam	ne (First, Middle	. Maiden Sui	mame)	
an	2 should be f and Mental b is marked of raumatic eve	To Be	Mahammed Bawa					Ashiawu				
~ <u>₹</u>	should nd Men marke	F	19a. Informant's Name/Relationship (	Type, Print)	1:	9b. Mailin	g Address (Street	and Number or Ru			own, State, Zig	Code)
ÛΣ̈́	7.2 = S		Jelili Ogundele	-Hughand		5610	Laurole	on Avenue	Dale		1 0101/	
3 ē	s 1 er f Hea ltem othe		20a. Method of Disposition		20b. Place	of Dispos	sition (Name of satory or other pla		Date Balt	20c. Locati	d 21214 tion - City or To	own, State
. <del>Z</del> €	Pages nent of l int: If It		tX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		l .		orial Pa		-2006	Randal	llstown	n. Md
Law Baltimore,	permit. Page Depertment of Important: If eny injury or once.		21. Signature of Funeral Service Lice	nsee	1911		Name and Addre		farch F		est	i, iid
m	Deperment of the perment of the permet of th		Nimette !	K- Imes			4300	Wabash A	venue	Balto,	, Md 21	215
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. D	o not ente	r the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pulmonar		lus						Onset and Death
	/Medical		resulting in death)	a	a consequence							
	Examiner		Sequentially list conditions	Asystole								
	ם ב	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	e of):						
241	ecute and -trans	cam	that initiated events resulting in death) Last	C. Due to (es es		0						
60,	cien a	<u>E</u>	,	Due to (or as	a consequenc	e or):						
n8.09289	licate be executed physicien and s the burial-transit	edicai	•	d								
× 6		/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy					224	Data of data	
Вох	eeth cer attendir for use	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal dea		Ectopic pregnancy Other (specify)	У		230.	. Date of delive Month	Day Year
P.O.	thet the de ed by the detached	Physician/M	1 Uyes 2 No 9 Unknown	9□ Unknown			Other (Specify)					
0	thet ned b	y P	Part II. Other significant conditions	contributing to death b	ut not resulting	g in the un	derlying cause giv	ren in Part I.	23e. Did	tobacco use	contribute to ti	he cause of death?
rds	quires n sign	d by							10	Yes 2□N	lo 3 □ Prob	pably 4 Unknown
Ö	w requir s been si should	jete							24a. Was	an 2	4b. Were auto	psy findings available
æ	The lav	Completed		-						psy ormed?	prior to co death?	mptetion of cause of
ta	an: ] tificel tor, p	BeC	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes		1 🗌 Yes	2 No
>	ysiclan: is certific director,	To B	examiner? 1 ☐ Yes 2 No	Hospital:	ent 2 ER/	Outpatient	3□ DOA Ott				Other (Specif	(v)
0	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Inju	ry 28b	. Time of Injury	28c. Injur Wor		28d. Describe			
0	andir sath. or: Af he fu	atic	Natural 5 Pending investigation	n	,,	qu.y	M 1 🗆	Yes 2 □No				
Division of Vital Records,	r Att	Certification;	3 Suicide 6 Could not be determined	286. Flace of Inj	ury - At home, c. (Specify)	farm, stre	et, factory, office			Street and Ni wn, State)	umber or Rura	I Route Number,
٥	rs af	S	<b>S</b>									
	To the Hospital or Attending Physician: The law requires thet the deeth certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	ledicai	29a. Certifier Check only one) Certifying Medical Example 1	ysician: To the best niner: On the basis o	f examination :	lge, death and/or inv	occurred at the tire estigation, in my o	me, date and ptace, ppinion, death occur	, and due to the rred at the time,	cause(s) and date and pla	d manner as since, and due to	tated. the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and the of certifier	and manner st	ated.		29c. Licens	se number		29d Date si	igned (Month,	Day Year)
	To Yill		Your	21			3	1700	9	۲3		
			30. Name and address of person who	completed cause of d	leath (Item 22	a) (Type I	Print)	1	ute -		1, 110	
	5		SS. Figure 2.13 approved of person with	105	69	1 /	hante	5+ 3	10	Tows	an Me	1 2404
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registr	ar's Signature		M. 2			000		
	Registr	ar	AUG 2 9 200	16 199 166	15	500						

		•	For State Registrar	State of Maryla	•	artment of Health and M rtificate of Death		<sup>ene</sup> 2006	27191
	Physici	an	1. Decedent's Name (First, Middle, Las.	150/1/ET	- <i>T</i>		2. Date of Death Month	Day Year	3. Time of Death
)	/Medic Examin	_	4a. Facility Name (If not institution, give	street and number)	-	4b. City, Town, or Location of Death	08	20 2006 4c. County of Death	3:04a
	Funeral Director		Joseph Richey 5. Social Security Number 6. Se	Hospice In	C . rs. last birthday) Yrs.	Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Cour	lace (State or Foreign
	pu .		Usual Residence of Decedent  10a, State 10b, County	10c.	City, Town or Lo	cation		1	0d. Inside City Limits
	Maryla 1 eho	٥	MD NA		Balti				XXYes 2 □ No
	deeth with the Maryland me 23a or 28a-f ehow rmust be notified at	Director	10e. Street and Number			10f. Zip Code	10	g. Citizen of What Cour	itry?
	th with		913 Lyndhurst	Street		21229		U.S.A.	
Maryland 21215-0036	s 1 end 2 should be filed within 72 hours efter deeth with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "neturel", or iteme 23s or 28s-1 ehow other traumatic event, its Madical Estimiter must be notified at	by Funeral	11. Marital Slatus  1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1Y Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (Sp. if Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 1 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: B	
ည	72 hc	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occupation kind of work done during most of work	ing 1	6b. Kind of Business/Inc	dustry
121	within ane. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)  Construction Wo	rker	Construct	ion Co
2	Hygie other	Be Co	10th grade  17. Father's Name (First, Middle, Last)	na		18. Mother's Name			.1011 001
/lan	2 should be and Mental Is marked of aumatic even	ToB	Eli McDonald			Harriet	t Benne	ett	
Jan.	2 sho		19a. Informant's Name/Relationship (7	•		ng Address (Street and Number or Run			
	1 end Health em 27 ther tr		Rosella Watkin 20a. Method of Disposition		. Place of Dispo	oodshire Court,		NOTE, MG Oc. Location - City or To	21244 wn, State
Baltimore,	Page ento nt: ⊮ ry or		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Gá	arrisor	natory of other place)  n Forest Vet 8/			
Ba	permit. Departm importe any inju		21. Signature of Funeral Service Licens	arch	Má	2. Name and Address of Facility arch F/H West 300 Wabash Ave,	Baltin	nore. Md	21215
30.	Physicien be executed by Medical Examiner physicien and present as the purish-transit	ıl Examiner	23a. Part . Enter the disease, or composition, or heart failure. List only of lists are condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	sequence of):	er the mode of dying, such as cardiac of CiARCI'WOM	or respiratory arre	st,	Approximate Interval Between Onset and Death
P.O. Box 68760,	Attending Physicien: The law requires thet the death certificate in death. r death. ector: After this certificete has been signed by the attending physis by the funeral director, page 2 should be detached for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	d	etal death 3 [ of death 5 [	☐Ectopic pregnancy ☐ Other (specify)	23e. Did tob	23d. Date of deliver Month	Day Year
rds,	w requires to been signer should be								ably 4 □Unknown
Division of Vital Records,	: The law recete has be pege 2 sho	Completed					24a. Was an autopsy perform 1 \( \text{Yes} \) 2	prior to conded? death?	psy findings available inpletion of cause of 2 No
Ĭ.	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		0.1	h (Check only one		11 0
on of	To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year		1 3 DOA 4 Nursing Ho	me 5 ☐ Resider 28d. Describe hov	nce 6 <b>Other</b> (Specifi w injury occurred	1) Hosfice
Divisi	i eff o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	reet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rura State)	l Route Number,
	To the Hospital or within 24 hours effect to the Funeral Dir. completely filled in I	edical C				h occurred at the time, date and place, vestigation, in my opinion, death occurr			
	To thi within To the	Me	29b. Signature and title of certifier			29c. License number	29	d. Date signed (Month,	Day, Year)
				In/		D14221		8.20.	00
	GH1		30. Name and address of person who of	completed cause of death (I	tem 23a) (Type,	Print) POLT MD	2/22/	,	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 9 200	32. Registrar's Si	gnature for	Print)  Print)  Print)  Print)  Print)  Print)  Print)  Print)			

Leon Bennett

			State of Maryland / Department of Health and Mental Hygiene 1- For Registrar Amend item#25,28b,perME,g859,9/7/06 Certificate of Death Reg. NO. 27192
	Physic	ian	1. Decedent's Name (First, Middle, Last)  Sarah L. Bowie  2. Date of Death Month Day Year  August 26 2006 3:40 pm
	/Medi Exami		Saran L. Bowle  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	- LXaiiii		SINAL HOSPITAL OF BALTIMORE BALTIMORE CITY
	Funeral Director		5. Social Security Number 578-40-4581  6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 4. Months Days Hours Min. 4. Aug. 25, 1930  9. Birthplace (State or Foreign Country) MO
	pug A		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	deeth with the Maryland ms 23a or 28a-f show Linual te notified at	tor	MD Carroll Sykesville
	th the or 28a	lrec	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	eth wi	ral	4809 Cherry Tree Lane 21784 USA 11 Morital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No. 14, Bace - American Indian,
W	ā 2 2	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  15. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No Specify: Specify: White
BowiE	21215-0036 ad within 72 hours atl glene. er than "natural", or t, the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry
100	VITAL	ошр	Elementary/Secondary (0-12)  College (1-4or 5+)  Accounts Manager Accounting
_	nd he filed al Hyg	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surmame)
0	ylal ould b Menti	10	James William Floyd Lucille Moore
7	Maryland d 2 should be file th and Mental Hy 27 is marked oth traumatic event	1	19a. Informant's Name/Relationship (Type, Print)  Mr. Robert Moody (Son)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  4809 Cherry Tree Lane, Sykesville, MD 21784
I	re, land Heali		20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State
AKAH	altimore, mit. Pages 1 a parlment of Het portant: If item y injury or othe ca.		Lake View Mem. Park 8/30/2006 Sykesville, MD
SAI	Balt permit. Departr Imports any inju		21. Signature of Funeral Service Licensee  Pular L Hourt
'	- 5 × -		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onese and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Sub Dural Hematoma
	/Medical Examiner		Due to (or as a consequence of):
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):
1)-	760, C	Examiner	that initiated events c.
	60, C	calE	Due to (or as a consequence of):
	687 tiflicate ig phys		d
	Box eath cer attendir for use	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1
	Division of Vital Records, P.O. to Attending Physician: The law requires that the dafter death. Director: After this certificate has been signed by the Lin by the funeral director, page 2 should be detached.	þ	Part It. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes   2   No   3   Probably   4   Unknown
	COT Iw requ	lete	24a. Was an 24b. Were autopsy findings available
	Vital Rec sician: The law scertificate has b lirector, page 2 s	Completed	autopsy prior to completion of cause of death?  autopsy prior to completion of cause of death?  1□ Yes 2 ☑ No
	Vita Iclan: Sertific ector,	Be	25. Was case reterred to medical examiner?  Hospital: 4 Control of Death (Check only one)
	Physical direction	.: To	1 I Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Hesidence 6 Other (Specify)
	ion nding ath. r: Afte	atlor	27. Manner of Death  1 Natural 5 Pending 2 DAccident investigation  28a. Date of Injury (Month, Day Year)  8/22/2006  28b. Time of Injury unk.  1 Natural 5 Pending 2 DAccident investigation  28d. Describe how injury occurred  Work?  1 Yes 2 No  5 Uh RC + C
	Or Atte or Atte after dea Directo	Certification:	3 Suicide 6 Could not be determined 28e Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  480 Cherry Tree (GWC)
	Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifice completely filled in by the funeral director,	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within To the	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)
			Remarks Goberonist, mo BG 9427394 AUGUST 26 2006
	15		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KENNEOY GABREGIORGISH, MD BALTIMORE CITY MARYLAND  31. Date filed (Month, Pay, Year)  AUG 2 9 2006
		tate	31. Date (iled (Month, Pay, Year)  32. Registrar's Signature
	Regis		AUG 2 9 2006

			1 - For State Registrar	State of Ma	arylan	d / Depa <i>Cei</i>	artmen rtificat	t of H e of L	ealth a Death	nd Me		ien <b>2</b>	006	27193
	Physici	20	1. Decedent's Name (First, Middle, Last			n	,	10			Date of Deat	h Day	Year	3. Time of Death
	/Medic		Vilma	1		150.			rque	1/	higust	25	2006	0307 PM
	Examin	er	4a. Facility Name (If not institution, give	11					Location of		•	4c. C	ounty of Death	1
			THE JUINS HOPKIN, 5. Social Security Number 6. Se			last birthday)		1 Year	If Under 2	4 Hrs.   g	. Date of Birth	1	9 Right	place (State or Foreign
	Funeral Director			M 28 F	43	Yrs.	Months	Days	Hours	Min. J	(Month, Day, uly 26	Year)	63 Nev	intry) York
			Usual Residence of Decedent											
	nylan how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits 1 Yes 2 □ No
	Be-f	cto	PA Lancaster		Lan	caster								
	vith th	Director	10e. Street and Number				10f. Zip						n of What Co	intry?
	s 23e	eral	1322 Shreiner Road	#B102	Ever in II	S 12 1		601	enanie Orio	in? (Speci	fy Yes or No-	U.S.	A . Race - Amer	ican Indian
	fler d	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		'	f Yes, spec	cify Cuba	n, Mexican,	Puerto Ri	can, etc.)		Black, White	
93	ers a	by	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1X Yes	2□ No	Specify:	uerto	Rico	S	pecify: W	hite
9	72 hours after death with the Maryland Insturet, or tems 23s or 28s-f show disal Essociate must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation campleted)		16a. Deced	dent's Usua	al Occupa	ation			16b. Kind	of Business/l	ndustry
2	within ene. then	npie.	Elementary/Secondary (0-12)	College (1-4or	5+)				furing most )			D	a.	
2	e filed within at Hygiene. I other then " went, I're Me		12 17. Father's Name (First, Middle, Last)			Assis	tant	Phar			First, Middle, N		g Stor	e
anc	d be f	Be	Jorge Osvaldo Bob	e Acerrado							Rodrig			n
Maryland 21215-0036	ges 1 end 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If of Health and Mental Hygiene is naturel; or thems 23a or 28e-f show it flems 27 is marked other than "naturel; or ther treumatic event, tra Madical Examinar mant be notified at	၉	19a. Informant's Name/Relationship (T)			19b. Mailir	ng Address	(Street a						
<b>≥</b>	alth ar 27 is r treu		Israel Gonzalez S	•	Danu						Lancas			
ē,	s 1 end 2 of Health a Item 27 is other tree		20a. Method of Disposition			Place of Dispo	sition (Nan	ne of ther place	9)	Dat	9 2	20c. Loca	ation - City or 1	own, State
	Pages nent of i		1  Burial 2  Cremation 3  F 4  Donation 5  Other (Specify)	lemoval from State	1	rta Fe	-		-	/31/0	6	San (	German,	PR
Baltimore,	permit. Page Department of Important: If eny Injury of once.		21. Sign ture of uneral Service Licens			22 H.	Name an	d Addres	s of Facility	/ 1 Hom	10			
	207 2 9		Janus Ke	Unem							e oklyn,		11208	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List onty o	ications that caused ne cause on each li	d the deat ine.	h. Do not ent		41			-	st,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Hype	rtig	phic	Cor	dro	nyo	pa Di	ry			3 /Eatils.
ſ	/Medical Examiner		resulting in dealth)	Due to (or as	a conseq	uence of):								
		9	Sequentially list conditions,	Due to (or as	a conseq	uence of):							-	
	uted ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events											
o,	exec en an rial-tr		resulting in death) Last	Due to (or as	a conseq	uence of):								
8760,	icate be executed physicien and s the burial-transit	Physician/Medical		d										
	death certifica ettending ph for use as t	Med	IF FEMALE:											
Вох	death certific e ettending p id for use as	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome	2 Feta	Ideath 3	Ectopic pr					23	<li>d. Date of deliver Month</li>	rery Day Year
o.		ysic	1 ☐ Yes 2 🕱 No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	t time or a	eath 5	Other (sp	өспу)						
P.0	requires that the de teen signed by the e hould be detached f		Part II. Other significant conditions co	ntributing to death b	out not res	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did tob	acco use	contribute to	the cause of death?
ds	n signe	d by									1 🗆 Ye	s 2 🗆	No 3∏Pro	bably 4 Unknown
000	> 10 0	ompieted									24a. Was ar		24b. Were aut	opsy findings available
æ	re h	E									autops perform 1 Yes 2	red?	death?	ompletion of cause of 200 No
ita	ysicien: T is certificat director, p	BeC	25. Was case referred to medical examiner?						26. Place	of Death /	Check only on			
<u>&gt;</u>	99	2	1 ☐ Yes 2 No			ER/Outpatier			4 🗀 1401	sing Home	5 🗆 Reside	nce 6	Other (Spec	fy)
Ē	ing P	inol	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury		8c. Injury Work			d. Describe ho	w injury	occurred	
isi	Attending r death. ctor: After by the fune	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inj	iunc. At h	ama farm str	M not factor		Yes 2□N		f Location (St	root and	Number of Pu	ral Route Number,
Division of Vital Records,	2 2 2 2	ertification:	4 Homicide determined	building, et	c. (Specif	y)	eer, ractory	y, onice		20	City or Town		Trumber of Fig.	ai noute ivalibel,
	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director; completely filled in by the	edical C	29a. Certifier 1 Cartifying Phy (Check only one) 2 Medical Exami	nar: On the basis o	f examina	wledge, death	n occurred vestigation	at the tim	ne, date and pinion, deat	d place, and	d due to the ca at the time, da	use(s) a ate and p	nd manner as lace, and due	stated. to the cause(s)
	o the o the omple	Med	29b. Signature and title of certifier	and manner st	aled.		290	c. License	number		29	d. Date	signed (Month	, Day, Year)
	r s ⊢ ŏ		1 9 U.L.	1						00	1	rigi	st 75	, 2006
7			30. Name and address of person who c	ompleted cause of c	death (Iten	n 23a) (Type.	Print)							13515
	2		J. GEOFF ALLE		-	600	ON S	RPK	Wor	FE :	STREET	1	MARMORE	7.2006 21281 MAR TANO
	Sta	-	31. Date filed (Month, Day, Year)	32. Régistr	rar's Signa	iture	9							
	Registr	ar	AUG 2 9 20	06 100	15.5	IF A	234/2	P						

State of Maryland / Department of Health and Mental Hygiene 2006

Certificate of Death

2	7	1	9	4
3. Ti	me d	of D	eath	

Physici /Medio Examin	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director pane? Should he detached for use as the burial-transit.	

		State Registrar  1. Decedent's Name (First, Middle, Last)		Certi	ficate of I	000111	2. Date of Dea	Reg. No.		3. Time of Death
hysicia		Elmer I	ee Bland				Month August	21, 20	Year 06	2:15 P <sup>M</sup>
/Medica xamine	_	4a. Facility Name (If not institution, give s		4	b. City, Town, or	r Location of Dea		4c. County		
, Ž., ž		Washington Adven	tist Hospital	L	Takoma	Park			gome	
eral ctor		244-56-4686	7. Age (in yrs. i		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		<sup>h</sup> , <sup>γ, γθας)</sup> , 4 <b>,</b> 1938	9. Birthp Cour	lace (State or Foreign htry) NC
	-	Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Local	tion				1	0d. Inside City Limits
				ok1yn						1⊠Yes 2 No
	Director	NY Kings  10e. Street and Number	DIC	JOKLYII	10f. Zip Code			10g. Citizen of V	What Cou	ntry?
		97 Brooklyn Ave.,	Apt #2_M		11216			USA		
	Funeral		2. Was Decedent Ever in U.	S. 13. Wa		lispanic Origin? (	Specify Yes or No- rto Rican, etc.)		e - Americ	an Indian,
,	۵	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □Yes 2 □XNo If Yes, Give Year or Dates:		es, speciny Cuba	Specify:	no Hican, etc.)	1	k, White,	
	ted	15. Decedent's Educ	cation	16a. Deceder	nt's Usual Occup	ation	advina	16b. Kind of B	usiness/In	dustry
	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	l		during most of wo	9			
	Completed	10		Chauff	eur			Transp		ion
l	Be	17. Father's Name (First, Middle, Last)					ime (First, Middle,	Maiden Suman	10)	
	۵_	William Bland				Eva I			-	
I		19a. Informant's Name/Relationship (Typ	oe, Print)				Rural Route Numbe			
	-	Joyce Bland/Wife	20h P	97 Br		Ave., A	t. #2-M,	Brook1		
		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ R		emetery, cremai	tory or other place	1			,	
		4 □ Donation / 5 □ Other (Specify)		rong-Bl metery				Vancebo		
	П	21. Signature of Funeral Service License	John C	Y	Name and Addre		Rivers C Lizabeth		-	neral Home 17909
	_	Julie !	Cook S						140 3	Approximate
ı	1	23a. Part . Effer the disease, o complished, heart failure. List only on	e cause on each line.	A. Do not enter	the mode of dyn	ig, such as cardie	ac or respiratory ar	1851,		Interval Between Onset and Death
ı	1	Immediate Chuse (Final disease or condition resulting in death)	- H Cal	e C	erel	no VE	if Calo	1 acc	ide	
ı		resulting in death)	Due to (or as a consequence	uence of):						
ı		Sequentially list conditions,		eps	CS_					
١	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (of as a collisey	derice of):	0	Λ.	fail	(	1	
	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	wance of):		enal	Japl	inte		
			540 10 (5. 45 4 55.1554	30,133 317.						
Ì	edical						<del>-</del>			
-	-	IF FEMALE: 2	3c. If yes, outcome of pregna	ancy				23d Da	te of deliv	erv
ı	gal	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3□E	ctopic pregnancy Other (specify)	/			nth	Day Year
	Physician/N	1 □ Yes 2 ☒ No 9 □ Unknown	9□ Unknown				53.5			
	Ph.	Part II. Other significant conditions con	tributing to death but not res	ulting in the und	erlying cause giv	ren in Part I.	23e. Did to	obacco use con	ribute to t	ne cause of death?
	d by						1 🗆 🗅	res 2 □ No	3 Prob	ably 4 Munknown
	ompleted						24a. Was	an 24h	Wara auto	psy findings available
ŧ.	mp						autop	rmed?	prior to co death?	mpletion of cause of
1	O.						1 ☐ Yes			2 No
	O	05.144						-14		
١	Be	25. Was case referred to medical examiner?	lospital:	50.0	- I Oth		eath Check only o			
	To Be	examiner? 1 Tes 2 A No		ER/Outpatient		er: 4 Nursing	eath <i>Check only</i> of Home 5 Resid	dence 6 Oth		y)
	To Be	examiner? 1  Yes 2 No  27 Manner of Death 1 Natural 5 Pending	lospital: 1 ⊠ Inpatient 2 □ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injur Wor	er: 4 □ Nursing y at rk?	eath <i>Check only</i> of Home 5 Resid			y)
	To Be	examiner?  1 Yes 2 🗷 No  27. Manner of Death  1 🛣 Natural  2 Accident  3 Suicide  6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1	er: 4 Nursing	Home 5 Resident 28d. Describe 1	dence 6 Oth	red	iy) ai Route Number,
	To Be	examiner? 1 Yes 2 No  7. Manner of Death 1 Natural 2 Accident investigation	I Minpatient 2	28b. Time of Injury	28c. Injur Wor M 1	er: 4 □ Nursing y at rk?	Home 5 Resid	dence 6 Oth	red	
	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  1 Certifying Physical Physical Science Could not be determined	28a. Date of Injury (Month, Day Year)  28a. Place of Injury - At he building, etc. (Specif sician: To the best of my kno	28b. Time of Injury ome, farm, stree by)	28c. Injur Wor M 1 at, factory, office	ier: 4 □ Nursing y at k? Yes 2 □ No	Home 5 ☐ Resident 28d. Describe No. 28d. Location (3 City or Townson, and due to the	dence 6 Oth now injury occur  Street and Numbern, State)  cause(s) and m.	ned per or Run anner as s	al Route Number,
١	To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Notural 5 Pending investigation  3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier (Check only one)  1 Certifying Physical Examination (Check only one)	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At he building, etc. (Specification: To the best of my known of the state	28b. Time of Injury ome, farm, stree by)	28c. Injur Wor M 1 at, factory, office	y at k? Yes 2 No	eath Check only of Home 5 Residue 28d. Describe to 28d. Location (City or Toxice, and due to the curred at the time,	dence 6 Oth now injury occur  Street and Numbern, State)  cause(s) and m.	ner or Run anner as s and due t	al Route Number, tated. o the cause(s)
	edical Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only)  1 Yes 2 No   28a. Date of Injury (Month, Day Year)  28a. Place of Injury - At he building, etc. (Specif sician: To the best of my kno	28b. Time of Injury ome, farm, stree by)	28c. Injury M 1 1 28c. Injury Nor 1 28c. Injury	er: 4 Nursing y at k? Yes 2 No me, date and place pinion, death occurrence number	eath Check only of Home 5 Residence 28d. Describe to 28d. Location (5 City or Toute, and due to the curred at the time,	dence 6 Oth how injury occur  Street and Number of	ned ner or Runa anner as s and due t d (Month,	al Route Number, tated. to the cause(s)  Day, Year)	
Ì	edical Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28a. Date of Injury (Month, Day Year)  28e. Place of Injury · At he building, etc. (Specif er: On the best of my kno ner: On the basis of examina and manner stated.	28b. Time of Injury  ome, farm, stree  y)  owledge, death of tion and/or investignts.	28c. Injury Wor  It, factory, office eccurred at the tir stigation, in my co	y at k? Yes 2 No	eath Check only of Home 5 Residence 28d. Describe to 28d. Location (5 City or Toute, and due to the curred at the time,	dence 6 Oth now injury occur  Street and Number, State)  cause(s) and madate and place,	ned ner or Runa anner as s and due t d (Month,	al Route Number, tated. to the cause(s)  Day, Year)
	edical Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who co	28a. Date of Injury (Month, Day Year)  28e. Place of Injury · At he building, etc. (Specif er: On the best of my kno ner: On the basis of examina and manner stated.	28b. Time of Injury  ome, farm, stree  y)  owledge, death of tion and/or investing a control of the control of	28c. Injury Wor  It, factory, office  accurred at the tir stigation, in my office  29c. Licens	y at k? Yes 2 No me, date and place opinion, death occurrence number	eath Check only of Home 5 Residence 28d. Describe 1 28f. Location (5 City or Toutle coursed at the time,	dence 6 Oth how injury occur  Street and Number of	ner or Run anner as s and due t d (Month,	al Route Number, tated. to the cause(s)  Day, Year)
	Medical Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28a. Date of Injury (Month, Day Year)  28e. Place of Injury · At he building, etc. (Specif er: On the best of my kno ner: On the basis of examina and manner stated.	28b. Time of Injury  ome, farm, stree  owledge, death of tion and/or inve-	28c. Injury Wor  It, factory, office  accurred at the tir stigation, in my office  29c. Licens	y at k? Yes 2 No me, date and place opinion, death occurrence number	eath Check only of Home 5 Residence 28d. Describe 1 28f. Location (5 City or Toutle coursed at the time,	dence 6 Oth how injury occur  Street and Number of	ner or Run anner as s and due t d (Month,	al Route Number, tated. to the cause(s)  Day, Year)

06-06215 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Stuart Albert Bates 1- For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day August 19, 2006 Medical Examiner Stuart Albert Bates 4b City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Pikesville Baltimore County 9064 Balin Court If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Foreign Days Months Hours Director Hartford, 1 X M 2 048-38-4049 56 1950 Usual Residence of Deceden 10c. City. Town or Location 10d Inside City Limits Pikesville 1 X Yes 2 No Maryland Baltimore 28a-f show 23a or 28a-f sho notified at once. death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9064 Balin Court 21208 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black 11. Marital Status Was Decedent Ever in U.S. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Armed Forces? 1 Never Married 2 2 X No Yes Yes 2 X No specify. hours after 4 X Divorce Yes, Give Year Specify: White 3 Widowed Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 hear of Health and Mental Hygiene ant: If item 27 is marked other than "r or other traumatic event, the Medical E Baltimore, MD 21215-0036 State Trooper Law Enforcement 5+ 17, Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Audrey Wilkinson John Calvin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) West Lebanon, NH 03784 Eric Bates (Son) 6 Orcutt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Important: J 8/21/06 Metropolitan Crematory Alexandria, VA Donation 5 Other Specify 22 Name and Address of Facility ignature of Funeral Service Lice Ricker Funeral 56 School St., Home Lebanon, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and tran Physician/Medical X UNPENDED X AMENDED rsician a item#23a,27,28a,28b,28e, 28f, preME,G859,9/11/06 TT Box 68760. IF FEMALE 23c If yes, outcome of pregnancy 23d Date of delivery phy the 23b Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death Dav past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an has been autopsy prior to completion of cause of death? performed? ✓ Yes 2 2 No this certificate 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 DOA Nursing Home 5 Residence 6 Other. Scene ER/Outpatient 3 1 V Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification: 1 X Natural FOUND Yes 2 No Pending Aug 19, 2000 the 2845 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined (Specify) Single Family 9064 Balin Court, Pikesville, MD within 24 hours a 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as starled. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifie O.C.M.E More 30. Name and a dress of person who completed cause of death (Item 23a) Assistant Medical Examiner 111-Penn Street, Baltimore, MD 21201

**OCME 2006** 

Registrar DHMH 17 Rev 1/2001

State

			1 - For State Registrar	State of Maryland	Cer	tificate of L	Death	Reg.		21190		
	Physici		1. Decedent's Name (First, Middle, I HANS G. BUTT					Date of Death Month IGUST 2	Day , 2006	3. Time of Death $5:20  a^{M}$		
	/Medic Examin		4a. Facility Name (If not institution, g			4b. City, Town, or TIMONI	Location of Death		4c. County of Death	1		
	Funeral Director		5. Social Security Number 6 078 – 30 – 2642	Sex 7. Age (In yrs. la. 70	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min. AU	Date of Birth (Month, Day, Y	9. Birth	nplace (State or Foreign untry) MANY		
	the Maryland 28a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  CA RIVERS		Town or Lo	cation LSINORE				10d. Inside City Limits 1 ☐ Yes 2 No		
	th with the 23s or 28 rst be not	<b>Funeral Director</b>	10e. Street and Number 16480 BAILEY	AVENUE		10f. Zip Code	2530	10g	. Citizen of What Col	untry?		
920	toges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23s or 28s-f show or other treumatic event, the Musical Examinational be notified at	by Funer	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 1 XYes 2 No If Yes, Give 50 S		Was Decedent of Hir f Yes, specify Cubar I ☐ Yes 2 No	spanic Origin? (Specify, Mexican, Puerto Ric Specify:	Yes or No- an, etc.)	14. Race - Amer Black, White Specify: WH	, etc.		
21215-0036	within 72 ho ane. than "natur be Medicel I	Completed by	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education prade completed)  College (1-4or 5+)	(Give life. L	dent's Usual Occupa kind of work done d OO NOT use retired, SALES	tion uring most of working	16	b. Kind of Business/I			
and 2	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Ma	To Be Co	17. Father's Name (First, Middle, La JOHANN BUTTN)	st)			18. Mother's Name (F		dle, Maiden Surname)			
Maryland	nd 2 shoul alth and M 27 is marl r treumati	1	19a. Informant's Name/Relationship INGRID BUTTN	(Type, Print)	19b. Mailin 164	ng Address (Street a	nd Number or Rural R EY AVE • I	oute Number, C	City or Town, State, Z LSINORE,	ip Code) CA. 92530		
Baltimore,	Tant tant		20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 4 □ Donation 5 □ Other (Spe		20c. Location - City or Town, State BALTIMORE, MD							
Balt	permit. Pa Departmer Important eny injury		21. Signature of Funeral/Service Lie	ONDCO		16924	YORK RD.	MONKT	ON, MD 2	SONS CO.		
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. METASTATIC A  Due to (or as a conseque	DENOC		g, such as cardiac or re	spiratory arrest		Approximate Interval Between Onset and Death		
68760,	ifficate be executed g physicien and as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	c.  Due to (or as a conseque  d.					-			
P.O. Box 6	the death certy the attendin	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Ectopic pregnancy Other (specify)		23d. Date of deli	very Day Year					
	9 D 9	ρ	Part II. Other significant conditions	s contributing to death but not result	ting in the u	nderlying cause give	n in Part I.		cco use contribute to	the cause of death?  obably 4xIUnknown		
II Reco	The law sete has b page 2 st	Completed						24a. Was an autopsy performe	d? death?	topsy findings available ompletion of cause of		
Vita	Physician: The this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death					
Division of Vital Records,	ding After fune	atlon: To	1 ☐ Yes 2 🛣 No  27. Manner of Death  1 🛣 Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day Year)	R/Outpatien 28b. Time of Injury	28c. Injury	4   Nursing Home	5 Residence Describe how	ce 6X1Other (Specinjury occurred	HOSPICE		
Divis	• Hospital or Attend 24 hours after deatl • Funeral Director: etely filled in by the	Certification:	3 Suicide 6 Could no 4 Homicide determina	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, str	eet, factory, office	28f.	Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,		
	To the Hospital or Atti within 24 hours after de To the Funeral Directi completely filled in by t	edical	29a. Certifier (Check only one)	Physician: To the best of my know aminer: On the basis of examination and manner stated.	riedge, death on and/or in	n occurred at the tim vestigation, in my op	e, date and place, and pinion, death occurred	due to the caus at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)		
	withii To th	ž	29b. Signature and title of certifier			29c. License		29d	. Date signed (Month	,		
	. 17		, /	7_			43725		8/28/	06		
5	111		30. Name and address of person when the second seco			,	TIMONIUM, N	m 2100°	2			
	Sta	te	31. Date filed (Month, Day, Year)	32 Appietrar's Signatu	ITO	_	TTEIONTON I	m 2109	)			
	Regist		AUG Z 9	2006	F. As	see						

DHMH 17 Rev 1/2001

AUGUST 26, 2006 5:20 a.m.

HANS BUTTNER

			1 - For State Registrar	State o	f Marylar		artment			and M	ental Hy	giene	006	271	97		
			Decedent's Name (First, Middle, La	st)							2. Date of De Month			3. Time of	Death		
	Physicia /Medic		Dorothy Ellen	Buckl	and						August			4:50	P M		
	Examin		4a. Facility Name (If not institution, giv		mber)				Location o	of Death	3	4c.	County of Death	1			
Ε	4		712 Lancaster		7 Ann (In	In a facing to the state of	Bel If Under	Air	If Under	24 Hre	O Data of Bio		Harford	(Cto to a	Foreign		
	Funeral Director		5. Social Security Number 6. S 226–28–6493	ex □M 21Σ(F	7. Age (In yrs.	82 Yrs.	Months	Days	Hours	Min.		nth, Day, Year) Country)					
127	*		Usual Residence of Decedent			02					Feb. 1	, 19	24 VIII				
-	nours arter death with the maryland turel', or items 23a or 28e-f show al Exercitær traust be notified at	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside C			
	86-1 s	Director	Maryland Harford		B∈	el Air					1				2 <del>∏</del> No		
	or 2	Dire	10e. Street and Number				10f. Zip					_	zen of What Co	untry?			
	eath y	Funeral	712 Lancaster D		edent Ever in U	I.S. 13.1		1014		gin? (Spe	cify Yes or No	USA	14. Race - Ame	ncan Indian.			
0	ritan	Fun	1 Never Married 2 Married	Armed Fo	orces? 2 <b>X</b> No	1				, Puerto F	cify Yes or No Rican, etc.)		Black, White				
0500-c	al', o	Ď	3 Widowed 4 □ Divorced	If Yes, Gir Year or D	ve lates:		1 ☐ Yes 2	2 <b>_3(</b> No	Specify:				Specify: W	nite			
ဂ ဂ	natur	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Deced	kind of wor	rk done a	luring most	t of workir	ng	16b. Ki	nd of Business/l	ndustry			
7	han han	mp	Elementary/Secondary (0-12)	College (	1-4or 5+)	_	DO NOT us	se retired,	)					<i>c</i> .			
V :	Hygie Hygie ther t		8 17. Father's Name (First, Middle, Last	)		Press	er		18. Mothe	r's Name	(First, Middle		thing Ma	anutact	urer		
yland	antal ced o	To Be	Robert Ellis	Caudil	1				Gene			eal	,				
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ž :	alth a alth a 27 ts		Linda Hopkins /	Daughte	r	712	Lanca	ster	Driv	ze. P	el Air	. Mar	ryland 2	21014			
J. G	of He of He rothe		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐	_	20b. F	Place of Dispo cemetery, crer	sition (Nan	ne of			ate	20c. Lo	cation - City or	Town, State			
Ē	Pag nent ent: If ury o		4 Donation 5 Other (Special		Ba	ltimor	e Nat	iona	1 Cen	n. 8-	30-06	Bal	timore,	Maryla	ınd		
Saltimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the warylar bepartment of Health and Mental Hygiene. Department of Health and Mental Hygiene importent: if ferm 271s marked other than "natural", or itams 23a or 28e-1 show any injury or other traumatic avent, the Medical Examinat ment be notified at once.		21. Signature 1 Funeral Service Licer	1500	/	M	. Name and	d Addres S Fu	s of Facility	. Hom	e, P.A	•					
2010	40 E = 0		steply UT	Jugs		1	317 C	<u>okes</u>	bury	Road	, Abin	gdon	, Maryla	and 210			
			23a. Part1. Enfer the disease, or com shock, or heart failure. List only	one cause on e	each line.			,			r respiratory a	rrest,		Interval Bet Onset and	tween		
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a			mic H	eart	Wsee	cse				2002	2-4lycan		
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<b>₹</b>	* **	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a consec	quence of):											
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-	ate be hysici the bu	Icai	•	d													
B S X	w requires that the death certifical been signed by the attending phenould be detached for use as the	Physician/Med	IF FEMALE:	220 16 1100 011													
XOD !	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live t	tcome of pregnations of come o	aldeath 3□	Ectopic pro						23d. Date of deli Month	-	Year		
o i	the deched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn		10am 5	1 Other (sp	өспу)									
7	requires that the seen signed by th hould be detache		Part II. Other significant conditions	ontributing to d	leath but not res	sulting in the u	nderlying ca	ause give	on in Part I.		23e. Did t	obacco u	se contribute to	the cause of	death?		
ras,	quires n sigr uld be	ed by									1 🗆	Yes 2	No 3□ Pro	obably 4 🗍	Unknown		
ecora	as bee 2 shou	olete									24a. Was		24b. Were au	topsy findings	available		
ř,	0 5 0	Completed									auto perfo	ormed?	death?	ompletion of d	ause or		
	ysician: In is certificate director, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only						
) o	W	To	1 Yes 2 No		<u> </u>	ER/Outpatier			.4 □ Nu				6 □Other (Spec	cify)			
		lon:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time of Injury		8c. Injury Work			8d. Describe	how injur	y occurred				
S	r Attending er death. rsctor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	e Zee Blees	e of Injury - At h	omo form et	M factors		Yes 2		19f Location /	Stroot an	d Number or Ru	iral Route Num	nhar		
=	n ite	Certification:	4 Homicide determined	build	ing, etc. (Speci	fy)	eet, ractory	r, omce		-	City or To			rai riodio ivan	1061,		
-	purs oral		29a. Certifier 12 Certifying Pl	nysician: To the	e best of my kno	owledge, deat	h occurred :	at the tim	ne, date an	d place, a	and due to the	cause(s)	and manner as	stated.			
;	24 hos 124 hos 18 Fun Istely	edical	(Check only 2 Medical Example)	miner: On the b	pasis of examina oner stated.	ation and/or in	vestigation,	, in my op	oinion, dea	th occurre	ed at the time,	date and	place, and due	to the cause(	5)		
1	To the complete	M	29b. Signature and title of certifier	License					te signed (Monti								
2.	4	1	- 10 mm	2	20			Ito	0544	39		August 28, 2004					
2			30. Name and address of person who	completed cau	se of death (Iter	m 23a) (Type,	Print)	201	L . 10	2 2							
			31. Date filed (Month, Day, Year)	224	B NOTE	ature et	5/0 1	sex "	ry M	VL	2014						
18-50	Sta Registi		AUG 2 9 20	06	se of death (Item B W N H Registrar's Sign	y fo	who										

State of Maryland / Department of Health and Mental Hygien 2006 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month **Physician** 23, 2006 10:02 AM August Patricia A. Bean /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 19541 Fetlock Drive Germantown Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🗓 F Yrs. 59 1946 Washington, DC Director 213-46-6373 Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any njury or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19541 Fetlock Drive 20874 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No II Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William David Perryman ဂ Bertha Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Floyd O. Bean, Jr./Husband 19541 Fetlock Drive, Germantown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State August 28, 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial 4 ☐ Donation 5 ☐ Other (Specify) 2006 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signal II - I Suneral Service Lice Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 M00803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction **Physician** /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Metabolic Syndrome The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☒ No detached 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signed should be d þ 1 Tyes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 Yes 1 ☐ Yes 2 ☐ No 215 No Division of Vital To this Hospital or Attending Physicien: within 24 hours after death.

Yo the Funerel Director: After this certifica completely filled in by the funeral director. p Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and file of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 20000995 23 30. Name are address of person who completed cause of death (Item 23a) (Type, Print)
Hector Asuncion, M.D. 18730 Liberty Mill Road, Germantown, Maryland 20874 Hector Asuncion, M.D. 31. Date liled (Month, Day, Year) 2. Registrar's Signature State Registrar

		1- State of Maryland / Dep	partment of Health and Nertificate of Death	fental Hygier	2000 21133
Physici		1. Decedent's Name (First, Middle, Last)  SOPHIE MARY ANN BLAT		2. Date of Death	24 2006 4.51 PM
/Medic Examin		4a. Facility Name (II not institution, give street and number) HARBOR HOSPITAL	4b. City, Town, or Location of Death BALTIMOR		4c. County of Death N/A
Funeral Director	9	5. Social Security Number 218 12 4184 6. Sex 1 7. Age (In yrs. last birthday 1 M 2 4 F 83 Yrs.	/ If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country) 1923 Mary Land
Maryland a-f ehow	ctor	10a. State 10b. County 10c. City, Town or I Maryland Anne Arundel Baltim			10d. Inside City Limits 1 ☐ Yes 2∑ No
with the a or 28 be not	Director	10e. Street and Number  205 - 2nd Avenue	10f. Zip Code 21225	10g.	Citizen of What Country?
iryland 21215-0036 should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "natural", or items 23a or 28e-f ehow mailc event, the Modical Examinar mast be millised at	by Funeral		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0035 d 2 should be filed within 72 hours af th and Mental Hygiene. 7 is marked other then "natural", or traumatic event, the Model Extra	Completed	(Specify only highest grade completed)  [Secondary (0.12)]  [College (1.407.5+)]	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) istered Nurse	sing	Kind of Business/Industry  Private Duty
Viand 2  buid be filed  Mental Hygiarked other atic event, II	To Be Co	17. Father's Name (First, Middle, Last)  Joseph Arkuszewski		e (First, Middle, Maid erine Swid	len Sumame)
Ma and 2 st lith ar 27 is r trau	7 100	Walter Blahut / son 6425	ling Address (Street and Number or Rui Golden Oak Drive	Linthicum	n, Maryland 21090
Baltimore, sernit. Pages 1 ar Department of Hea mportant: if them any njury or othe		4 Donation 5 Other (Specify) Holy Cro	ematory or other place) oss Cemetery 8/28	/2006 Ba	Location - City or Town, State  1timore, Maryland
The law requires that the death certificate be executed XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	edical Examiner	23a. Part I. Enter the disease of complications that caused the death. Do not enshock, or heart failure, Listonly one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):   nter the mode of dying, such as cardiac	ay Baltim or respiratory arrest,	ore, Maryland 21225  Approximate Interval Between Operational Power	
P.O. BOX 6 that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mogaths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Cords, P. w requires that the seen signed by should be detailed.			underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
II Records, The law requires the law been signed page 2 should be considered.	Completed by	· Stagely Chronic Kidney	ailure Lisease	24a. Was an autopsy performed	
of Vital Re Physician: The this certificate ha	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient	Othor	th (Check only one)	6 ⊟Other (Specify)
Division of Vital or attending Physician: T affer death. Director: Affer this certificate in by the funeral director, pa		27. Manger of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at	28d. Describe how in	
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)		City or Town, St	
e Hosp 24 hou e Fune letely fil	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the bast of my knowledge, dea one) 2 Medical Examiner: On the basts of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
10	1	30. Name and address of person who completed cause of death (Item 23a) (Type	Kes 000		MVST, 24, 2006
Sta Registi		SUBHASH BOSE 300 South  31. Date filed (Month, Day, Year)  AUG 2 9 2006	n Manoven Stacel	= 1Saltin	note, MD 21225

			For State Registrar	State o	f Marylan	d / Dep <i>Ce</i>	artment rtificate	of Hea	ith and Mo ath	ental Hygi Re	iene 2006	27200
			Decedent's Name (First, Middle, La	ıst)	<del>-</del>					2. Date of Death Month	h Day Yea	3. Time of Death
	Physicia /Medic		Robe	rt	F.	Baile	ey			August	23, 2006	
	Examin		4a. Facility Name (ff not institution, gi	e street and nu	mber)			Town, or Loca	ation of Death		4c. County of De	
			Carroll County H					Westmi	nster			roll
	Funeral Director			Sex 1X M 2□F	7. Age (In yrs.		Months .		Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, January	1,1941	Birthplace (State or Foreign Country) Maryland
	put &		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or L	ocation					10d. Inside City Limits
	ahor e hor	ō	Maryland Carroll			Hampst						1 ☐ Yes 2 🗹 No
	28a-1	Director	10e. Street and Number			namps	10f. Zip	Code		10	Oq. Citizen of What	Country?
	3a or		3207 Laverne Circ	·16			2	1074			U.S.A	١.
	death ms 2	Funeral	11. Marital Status		edent Ever in U	.S. 13.	Was Deced	ent of Hispar	nic Origin? (Specialistical)	cify Yes or No-		nerican Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other then "neturel", or items 23a or 28a-f ehow other treumatic event, the Medical Examinations and the notified at	by Fu	1 Never Married 2 XMarried 3 Widowed 4 Divorced	1 XYes If Yes, Gir Year or D	2 □ No ve 1.958 - 1 lates:	962	1 ☐ Yes 2	_	ресіту:	ncari, etc.)	Specify	White
21215-0036	2 hou	ted	15. Decedent's 8	ducation		16a, Dece	dent's Usua	I Occupation	a most of working		16b. Kind of Busine	
218	thin 7	Completed	(Specify only highest gi	College (	1-4or 5+)	life.	DO NOT us	e retired)	g most of workin	ig		
	filed wil Hygien other th	5		1		Т	echni					unications
Maryland	be fill htal H od oth	Be	17. Father's Name (First, Middle, Las					18.			Maiden Surname)	
yla	should ind Men in marke umatic	ဥ	Ralph  19a. Informant's Name/Relationship	Bailey		105 14-11		(Ctonat and t		lizabeth	City or Town, State	· J
Mai	12 sh th and 7 is n treun						•	•			9.00	
	1 and 2 Heelth tem 27 i	1	Kathy Bailey 20a. Method of Disposition	Wife_	20b. F	Place of Disp	osition (Nam	rne Ci			ad, Mary 1 a 20c. Location - City	
no			1 Burial 2 Cremation 3 Donation 5 Other (Spec	Removal from	State	emetery, cre 1top S	-		9-25	-2006	Towson	Maryland
Baltimore,	permit. Page Depertment of Importent: If eny injury of once.		21. Signature Furniral Service Lice		(1111		2. Name an	d Address of	Facility Rue	ck Towso	n Funera	Home, Inc.
	405 • a		Tank to tag		augad the deat	b Do set or		York R			Maryland 2	212U4 Approximate
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Вох	death certificate e attending phys id for use as the	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregna	ıl death 3	□Ectopic pr				23d. Date of Month	delivery Day Year
0	at the de by the a tached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn	nant at time of cown	eatn 5	Other (sp	өспу)				
Ω.	that t		Part II. Other significant conditions	contributing to d	eath but not res	ulting in the	underlying ca	ause given in	Part I.	23e. Did tob	pacco use contribute	to the cause of death?
rds	quires n sign uld be	d by								1 🗆 Ye	s 2□No 3□	Probably 4 Winknown
Ö	The law requires that ste hes been signed b page 2 should be deta	Completed								24a. Was ar	n 24b. Were	autopsy findings available
Re	The lar	E								autops perform	ned? death	to completion of cause of .? 'es 2□ No
ita		0	25. Was case referred to medical					26.	. Place of Death	(Check only on	A .	
<b>&gt;</b>	\$ p	ToB	examiner? 1 □ Yes 2 🕱 No	Hospital: 1 🗆	Inpatient 2X	ER/Outpatie	nt 3 DO	A Other:	4 ☐ Nursing Hon	ne 5 Reside	ence 6 Other (S	pecify)
0 0	ding Ph h. After th funeral		27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time Injury		8c. Injury at Work?		28d. Describe ho	w injury occurred	
Sio	P S S S	cati	2 Accident investigati 3 Suicide 6 Could not	he -			М		2  No			
Division of Vital Records,	or Attenester deat Director: in by the	Certification:	4 Homicide determine	d 288. Placi	e of Injury - At h ling, etc. <i>(Speci</i>	ome, farm, s fy)	treet, factory	r, office	2	28t. Location (St. City or Town		Rural Route Number,
	pitai ours e erai [		29a. Certifier 1 Certifying F	hyeicien: To th	a boot of my ko	wladaa daa	th occurred	at the time of	tate and place a	and due to the or	ausols) and manner	as stated
	To the Hospital or Atti within 24 hours effer de To the Funeral Directo completely filled in by t	edical		miner: On the b							ause(s) and manner ate and place, and o	
	To the within 2 To the comple	Me	29b. Signature and title of confider				290	. License nu	mber	25	9d. Date signed (Me	onth, Day, Year)
	,- ,- o		· UKY.	AD				200 D	6575		08-25-	2006
-	DXI		30. Name and address of person who			п 23а) (Туре	, Print)					
V	7		DAVIDJ. HA			10155 Y			CKEYSVIL	LE, MD	21030	
0	Sta		31. Date filed (Month, Day, Year)	32.	Registrar's Sign	ature A	and a					
	Regist	ar	AUG 2 9 2	UUD	32.33 J	S. Jak						

			Please	Type or Print	in Black	Indelible Ink	. Ensure A	Il Copies A	re Legib	le.
_			1 - For State Registrar	State of Mar	yland / Do )	epartment of I	Health and N Death		$^{\rm ene} 200$	6 27201
		S	Decedent's Name (First, Middle, Last	st)				2. Date of Death	1	3. Time of Death
1 H 2	Physici		Virginia	A. Breide	nstein			Aug. 26,		3:15 A M
	/Medi Examir		4a. Facility Name (If not institution, give		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4b. City, Town,	or Location of Death		4c. County of	
٥			Oak Crest Village	e Care Cent	er		Baltimore			ltimore
20-	Funeral Director		5. Social Security Number 6. S 212-05-0196	ex	In yrs. last birth 94 Yi	Months Dave		8. Date of Birth (Month, Pay, OCt. 9,	<sup>Y</sup> 13911 P	Birthplace (State or Foreign Country) ennsylvania
96	pu .		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town	or Location				10d. Inside City Limits
£	the Maryland r28a-f show	2			oc. ony, rown		. 7			1 □ Yes 2 No
00	the M	Director	Md. Balt  10e. Street and Number	imore		10f. Zip Code	altimore	10	g. Citizen of Wh	at Country?
	with a s	Ö	8800 Walther Bl	vd.			21234		9. 0	USA
<u> </u>	death with the Maryland ms 23a or 28a-f show milled et	Funerai	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was Decedent of If Yes, specify Cub		ecify Yes or No-		American Indian,
VIKGINIA France		by Fur	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2X No If Yes, Give Year or Dates:		If Yes, specify Cut 1 ☐ Yes 2 No		Rican, etc.)	Black, Specify:	White, etc. White
$\bar{x}$	72 hours "natural",		15. Decedent's Ed	ducation	16a. D	ecedent's Usual Occu	pation	1	6b. Kind of Busi	
	on 72	Completed	(Specify only highest gra	de completed)  College (1-4or 5+)		Give kind of work done ife. DO NOT use retire	ed) during most of work	ring		•
5	d withir giene.	E OC	12	College (1-401 3+)		Supervis	or	(	C&P T	elephone
5	Maryland 2.12. nd 2 should be filed within the and Mental Hygiene. 27 is marked other than r traumatic event, the Maryland Maryla	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
~ <u>i</u>	Ment Ment	70	William	Grier			J	esse Fis	sher	
2	and and is ma		19a. Informant's Name/Relationship (			Mailing Address (Stree			-	
$\preceq$	of Health		Mr. John G. Grier							rginia 20120
SREIDENSIEIN,	Dallillore, Marylarid A.I.A.19-0030 sermit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. mportent: if Item 27 is marked other than "natural", or may holy or other traumatic event, the Medical Exam. page.		20a. Method of Disposition  1	Hemoval from State		Disposition (Name of crematory or other plant d Mem. Par				ty or Town, State e, Maryland
$\simeq$	Dallillo Dermit. Page Department of Important: if any injury or		21. Signature of Euneral Service Licer	-						1 Home, Inc.
$\Sigma$	0 88558		Mu			1050 York	Road To	wson, Mar	ryland 2	1204
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused th one cause on each line.	ne death. Do no	t enter the mode of dy	ing, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition	cere	2 brail	vase !	lar di	seas e		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a						
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Α,	De sis	luer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of	):				
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700	cate be physicial s the buri	de		d						
	BOX OC eath certific attending pl	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		_			23d. Date	of delivery
0	d for	ciar	in the past 12 months?	1 Live birth 2 4 Pregnant at tir		3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	cy		Month	
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	aw re	Completed						24a. Was an autopsy		ire autopsy findings available or to completion of cause of
Ċ	The lav	E						perform	ed? de	ath?  Yes 2 146
	VICIAN: The ician: The certificate rector, pag	Be	25. Was case referred to medicat examiner?				26. Place of Deat	th (Check only one		
3	OI V Physic this ce al dire	To	1 Yes 2 No			atient 3 DUA		ome 5 Resider	nce 6 Other	(Specify)
	ding Ph	 	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day )	(ear) 28b. Ti	ury Wo		28d. Describe hor	w injury occurred	
	SIO tendi for: A	cati	2 Accident investigation 3 Suicide 6 Could not b				]Yes 2 □No			
101	DIVISION OF VICE THE COLUS, F.O. BOX 00/00 he Hospital or Attending Physician: The law requires that the death certificate be n.24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physicial place in by the funeral director, page 2 should be detached for use as the but but the funeral director, page 2 should be detached for use as the but but the funeral director.	Certification:	4 Homicide determined		/ - At home, farr (Specify)	n, street, factory, office		City or Town,	eet and Number State)	or Rural Route Number,
(4)	To the Hospital or within 24 hours after To the Funeral Dir completely filled in		29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge,	death occurred at the t	time, date and place,	and due to the ca	use(s) and manr	ner as stated.
	n 24 he Fu	Medicai	(Check only 2 Medical Exar	niner: On the basis of ea and manner state		or investigation, in my	opinion, death occur	red at the time, da	te and place, an	d due to the cause(s)
	To the within 2. To the complet	Z	29b. Signature and title of certifier	4		29c. Licen	nse number	29	d. Date signed (	Month, Day, Year)
	1		1 am	snone	0	155	58646		August	36 2006
	6		30. Name and address of person who	completed cause of dea	ith (ttem 23a) (T				,	
	1		Anna Manies	8400	walth	or Boole	1000	Parkville	· MI	21234

DHMH 17 Rev 1/2001

State Registrar

Anna Month, Day, Year)

AUG 2 9 2006

Boulera rd

Parkville, MD 21234

32 registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 27202 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month August 28, **Physician** 2006 2:45 a M Bonaventura Rita /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 307 Quaker Ridge Road Timonium | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec. 3, 1931 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 € F 215-28-9816 74 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-f ehow the Medical Examiner must be notified at MD Baltimore 1 ☐ Yes 2 ☐ No Director Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 307 Quaker Ridge Road U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Marned 1 Yes 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☒ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrical Assembly Electronics 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be filk Department of Health and Mental Hy Importent: If Item 27 is marked oth eny liqury or other traumatic event SDES. 17. Father's Name (First, Middle, Last) Be Stacks Marie Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 Quaker Ridge Rd., Timonium, MD Carl J. Bonaventura-husband 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley 8/31/06 Timonium, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York RD., Towson, MD 21204 Approximate Interval Between Inset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Priysician MELASTATIC MONTHO /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine be executed burial-transit that initiated events resulting in death) Last i been signed by the attending physicien and should be deteched for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∰nknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an certificete hes autopsy performed? 2 No 1 Yes 2 ₹No 1 Tyes tal or Attending Physician: To sater death.

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It becomes the this certificet.

It is the funeral director, pa Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) မ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place ol Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital a within 24 hours aff To the Funerel Di 29a. Certifier 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and fittle of certifier 00 110 Name and address of pegeon who completed cause of death (Item 23a) (Type, Print) OSE NBLUM MA 600 OSCER 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 9 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006

			1 - State Registrar	State of Wi	arytanu / D	Certificate of	Death		eg. No.	21203
	Physici	an	Decedent's Name (First, Middle, La CARL	FRANCIS	BESSENT	-		2. Date of Dea Month AUGUST	27, 2006 eer	3. Time of Death 6:26P M
	/Medic Examin	al	4a. Fecility Name (If not institution, give		DESSEN		or Location of Death	August	4c. County of Dea	
	LXamii	e.	Edenwald			Tows			Baltimo	
	Funeral Director			Sex 7. Ag	e (In yrs. last birth Y	rs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day September	Year) 9. Bi 14, 1919 SO	rthplace (State or Foreign ountry) UTN Carolina
	yland		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	e Mar	ctor	Maryland Baltimo	re	Towson					1 □Yes 2√XNo
	ath with the 23a or 24	rai Dire	800 Southerly Roa	Υ		10f. Zip Code 21286			USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examination and injury or other traumatic event, Ite Medical Examination in Life of an once.	d by Funeral Director	11. Marital Status  1 Never Mamed 2 Married  3 Widowed 4 Divorced	12. Was Decedent Arrived Forces? VETYes 2 I If Yes, Give Year or Dates:		13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes XXNo		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
15-0	n 72 h "natu	lete	15. Decedent's E (Specify only highest gr	ade completed)		Decedent's Usual Occup 'Give kind of work done life. DO NOT use retire	pation during most of works d)	ing	16b. Kind of Business	s/Industry
212	d withii giene. rr than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Mechanica			Steel	
	be filed ntal Hygi od other event,	To Be C	17. Father's Name (First, Middle, Last Carl Bishop Besse				18. Mother's Name			
Maryland	should be nd Mental i marked o	2	19a. Informant's Name/Relationship		19b.	Mailing Address (Street	Edith Jo			Zip Code)
-	and 2 saith ar alth ar 127 la ar trau		Velma Elizabeth B			Southerly				
Baltimore	Pages 1 ament of He ant: If Item ury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 2  4 Donation 5 Other (Special Control of the		cemetery	Disposition (Name of crematory or other pla unt Cremato	ory 8/29/	06	20c.Location-City o Baltimore,	Maryland
Balt	permit. Departr Imports any inje		21 Signature of Funeral Service Lice	Iken Ke	nakis				lefeld Funera e, Marylan	
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	/Medical Examiner		resulting in death)	Due to (or as	a consequence o	1):	<del>/                                    </del>	Δ .		6.
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	tificate be executed ig physician and as the burial-transit	ledical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence o	w Alr	hermer	1) dr	em	syv.
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Vital	ian: T	0	25. Was case referred to medical				26. Place of Death		4	s 2□No
of V	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No	Hospital: 1   Inpatie		patient 3 DOA			ence 6 □Other (Spe	ecify)
ouo	After fune	tion;	27. Manner of Death  1 Natural 5 □ Pending  2 □ Accident investigation	28a. Date of Inju (Month, Da	y Year) 28b. Ti	jury . Wo	ry at rk? ] Yes 2 □ No	28d. Describe h	ow injury occurred	
Division	or Attending after death. Director: After in by the fune	ertifica	2 Accident investigation 3 Suicide 6 Could not to determined	28e. Place of Inj	ury - At home, far c. (Specify)	n, street, factory, office		28f. Location (Si City or Town	treet and Number or F n, State)	lural Route Number,
tund.	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification;	29a. Certifier Check only 2 Medicel Exe	miner: On the basis o	if examination and	death occurred at the ti for investigation, in my	opinion, death occurr	ed at the time, d	ate and place, and du	e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		4/	29c. Licen	se number	0 2	9d. Date signed (Mon	ty Day, Year) 06 1 4228
	10		30. Name and address of persop who	completed cause of o	leath (Item 23a)	Type, Print)	- ( 1 6	~ 1	•/ 51	1 71778
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	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 9 2006	32. Registr	rar's Signature	role	D			

State of Maryland / Department of Health and Mental Hygien 2006

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 7,23 PM Jugust **Physician** 23 2001 Sephine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE FRANKLIN WOODS NURSING HOME ROSSVILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/29/1912 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Days Hours 1 M 2 TyF MD. 94 Yrs. Director 213-01-3332 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location the Maryland 10a State item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event. It a Modical Executes the notified at 1 Yes 2 No Director ROSEDALE MD. BALTIMORE 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21206 UNITED STATES 5516 LANHAM WAY Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on tof Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Iter 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (1-4or 5+) UNKNOWN OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be FRANCES THANNER JOHN BRUTSCHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5516 LANHAM WAY, BALTIMORE, MARYLAND 21206 19a. Informant's Name/Relationship (Type, Print) JOSEPH P. HAMM/SON Health item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/28/06 BALTIMORE, MARYLAND MOST HOLY REDEEMER we of juneral several censee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a Part 1 Onset and Death Immediate Cause (Final disease or condition resulting in death) VOCa Physician /Medical Due to ( as a consequence of): Examiner onal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Box 68760, IF FFMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: After 5 Pending investigation 1 HNatural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 🗋 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Thomicide 24 hours a 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0 NAGr man 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9105 Franklin Syrace dmondson 31. Date filed (Month, Day, Year) AUG 2 9 32. Redistrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19a per inf 9859 9-1-06 vt.
State of Maryland Delagrage of Health and Mental Hygiene

			1 - For State Registrer	State of Maryland / Dep	ertificate of	Death			
ı	Physici /Medic		Decedent's Name (First, Middle, Last)     Frank		Cl	ark	2. Date of De. Month 08	18 200	3. Time of Death 7:35 M
7	Examin		4a. Facility Name (If not institution, give s			or Location of Deatl	h	4c. County of Dea	ath
			Bon Secours Hosp  5. Social Security Number 6. Sex		Baltin		8. Date of Bird	N/A	rthplace (State or Foreign
	Funeral Director			M 2□F 93 Yrs.	Months Days		(Month, Da	21 13	SC SC
	yland how		10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	8a-f	cto	MD NA	Balti					1 X Yes 2 □ No
	ter death with the Marylan Items 23a or 28a-f ehow Let must be cutified at	Funeral Director	10e. Street and Number	lin Charat	10f. Zip Code	21223		10g. Citizen of What C	-
	ms 23	era	2618 West Frank		3. Was Decedent of If Yes, specify Cub		pecify Yes or No		erican Indian,
036	E o at		1 ☐ Never Married	Armed Forces?  1 Yes, Give Year or Dates:	1 ☐ Yes 2 💯 No		to Rican, etc.)	Black, Whi	Black
<u>2</u>	"naturel",	eted	15. Decedent's Educ (Specify only highest grade	ation 16a. Dec	edent's Usual Occu ve kind of work done DO NOT use retire	pation during most of wor	rking	16b. Kind of Business	s/Industry
Maryland 21215-0036	within iene. than "	Completed by	Elementary/Secondary (0-12) 2nd Grade	College (1-4or 5+)	. DO NOT use retire Longshor			Ship Ya	rk
<u> </u>	be filed tal Hygie d other event, ti	Bec	17. Father's Name (First, Middle, Last)					Maiden Sumame)	
<u>Ş</u>		2	Frank B. Clark	8:4			Taylor		
	tra tra		Ratte Name/Relationship (Type Martha Clark-Wi	fe 261				or, City or Town, State, t, Balto,	Md 21223
Baltimore,	permit. Pages 1 an Department of Heal importent: if item 2 eny injury or other once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	position (Name of rematory or other place emorial		Date / 23/06	20c. Location - City of Randalls	r Town, State
Balti	permit. Departrimporte eny inju		21. Signature of Funeral Service License	~1/1	22. Name and Addr March F/ 4300 Wah	YH West	. Balt	imore, Mo	21215
			23a. Part . Enter the disease, or complic shock, or heart ailure. List only on						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Muscar	dIAL				5 m/Nut
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	, ,	, , , ,	, ,		
	,	Jer	Sequentially list conditions, b. if any, leading to immediate	Due to (or as a consequence of).					
7.	ecuted and -transi	Examiner	riany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
68760,	ificate be executed g physicien and as the burial-transit	edical Ex	d.	Due to (or as a consequence of):					
			IF FEMALE:			-			
D. Box	The iaw requires that the death cert lie has been signed by the attending age 2 should be detached for use a	Physiclan/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown		I∏Ectopic pregnanc i ☐ Other (specify) _	ey		23d. Date of de Month	blivery Day Year
s, P.O.	res that the de igned by the a be detached f	by Ph	Part II. Other significant conditions conf	tributing to death but not resulting in the	underlying cause g	ven in Part I.	23e. Did to	obacco use contribute t	
ord	n require been sig should t	ted					1 🗆 \	′es 2□No 3□P	robably 4 Onknown
Rec	The law ate has b page 2 sl	Completed				-		rmed? prior to death?	utopsy findings available completion of cause of
İ		BeC	25. Was case referred to medical examiner?			26. Place of Dea	1 ☐ Yes ath (Check only o		S 2L5140
<u>ŏ</u>	shys this al dir	ု	1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2 ER/Outpati	GIII 3L-DUA			lence 6 Other (Spe	ecify)
ono	ding After fune	tlon:	27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	Wo	nyat ork? ]Yes 2 ☐No	28d. Describe h	low injury occurred	
Division of Vital Records,	l or Attending efter death. Director: After i in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)			28f. Location (S City or Tou	Street and Number or R m, State)	tural Route Number,
_	Hospita 4 hours Funerei tely filled	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowledge, deer: On the basis of examination and/or and manner stated.	ath occurred at the tinvestigation, in my	ime, date and place opinion, death occu	o, and due to the ourred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 0 00 5	29c. Licen	se number		29d. Date signed (Mon	
	/		DR John	I galpin	0			8-18	7-2006
	3		30. Name and address of person who cor	mpleted cause of death (Item 23a) (Typ	e, Print)	Rall	1	2	1-2006
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signature	all i	130-6	Timos	to, Ilm	ry and
	Registr		NIC 2 9 2006	R M M					

	an	1 - Stata Registrar  1. Decedent's Name (First, Middle, Last  Edith Mae Cui	fley			2. Date of Death Month August 2	Day 2006	2 7 2 0 3. Time of Dea
Medic amin		4a. Facility Name (If not institution, give		4b. City, Town, o	or Location of Death	August 2	4c. County of Dea	11:55 ]
amm	Ç.	509 Green Stree			de Grace		Harford	
eral	O.	Social Security Number 6. Se		birthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye		thplace (State or Fo
ctor		212-32-1477	73	Yrs.			1932 Mar	yland
78		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location				10d. Inside City L
Dell	to	Maryland Harford	Hayre	e de Grace				1 X es 2
N LINE	Directo	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	ountry?
tant b		509 Green Street		2107			USA	
ner n	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 15 Yes 222 No If Yes, Give	13. Was Decedent of I If Yes, specify Cub	tispanic Origin? (Specan, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
xand	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2√2 No	Specify:		Specify:	hite
aumatic event, the Madical Exe	ted	15. Decedent's Edu (Specify only highest grad		6a. Decedent's Usual Occup (Give kind of work done		161	o. Kind of Business	
Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	d)	<i>ig</i>		
nt, the		17. Father's Name (First, Middle, Last)	E	lomemaker	10 Matheda Nama		Own Home	
	o Be		nderson		18. Mother's Name Jessie	Ella Mon		
matic	ř	19a, Informant's Name/Relationship (7)		9b. Mailing Address (Street				Zip Code)
=		Raymond B. Cuffle		09 Green Str				
other		20a. Method of Disposition	20b. Place	of Disposition (Name of other), crematory or other pla	Da		c. Location - City or	
any Injury or QDCB.	3	1 ☑Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	demoval from State	el Hill Cemet		06 на	avre de G	race, MD
ny Inj		21. mature of Fun cal Service licens	99	22. Name and Addre	ess of Facility uneral Hom	e. P.A.		
ā			nastour	-1317 Coke	sbury Road	, Abinada	on, Maryl	
4		23a. Part1. Enter the \ sease, or comp shock, or he in fallure. List only of	lications that caused the death one cause on each line.	o not enter the mode of dy	ng, such as cardiac or	respiratory arrest,		Approximate Interval Betwee Onset and Dea
cian lical		Immediate Cause (Final disease or condition resulting in death)		renal faile	we			Gnorths
iner			Due to (or as a consequent	ce of):				511000
Ø.,	Jer.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	ce of):				) year
e burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c					
al-t		resulting in death) Last	Due to (or as a consequence	ce of):				
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the funeral director, page 2 should be detached for use as the bur	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	1  Live birth 2 Fetal death 4  Pregnant at time of death 9  Unknown  Intributing to death but not resulting  Hospital: 1  Inpatient 2  EPV  28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At home, building, etc. (Specify)  sician: To the best of my knowled ther: On the basis of examination	Outpatient 3 DOA Other (specify)  g in the underlying cause given by the underlying cause given by the underlying cause given by the underlying cause given by the underlying allowed by the underlying by the und	26. Place of Death  Der: 4 Nursing Hom  Ty at rk?  Yes 2 No  2  The date and place, at appinion, death occurred se number	24a. Was an autopsy performed 1 Yes 2 (Check only one)  10 Yes 2 (Check only one)  11 Yes 2 (Check only one)  12 Residence 8d. Describe how in the City or Town, Sound due to the cause d at the time, date	24b. Were at prior to death? 1	robebly 4 Unkings avacompletion of caus  2 No  curfy)  ural Route Number,  s stated.  to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20061 - State Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician /Medical 4b. City, Town, or Location of Death County of Death Examiner Stella Mari Under 1 Year | If Under 24 Hrs. TIMORE Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours **1**∕2 M 2 □ F Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 ie marked other then "natural", or items 23a or 28a-f ehow other traumatic event. The Madical Examinar must be notified at 1 Yes 2 No Director more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. Never Married 2 Married Yes 2 □ No Maryland 21215-0036 1 ☐ Yes 2 No þ ff Kes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. Int: if item 27 is marked other then "n ty or other traumating. on ary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 idalstown MD 21/33 Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State permit. Pages 1
Depertment of H
Importent: if ite
eny injury or ot 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee un 23a: Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HUMAN IMMUNODEFICIENCY VIRUS /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) the page 2 should be detached 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? of Vital Records, ٥ 3 ☐ Probably 4 X Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was ...
autopsy
performed?

Ves 2X No this certificate has 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Certification: To 1 ☐ Yes 2**X** No 1 Inpatient 2 ER/Outpatient HOSPICE 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Division 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)
AUG 2 9 2006

DR. TARIQ MAHMOOD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

32. Digistrar's Signature

22,

AUGUST

VERNON DIXON

TIMONIUM, MD 21093

			State of Maryland / Department of Health and Mental Hygiene 2006 27208  Certificate of Death Reg. No.
		¥	1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death
	Physicia /Medic		Carlise Phyllis Davis August 26, 2006 1004 M
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  4c. County of Death  4d. County of Death
\$	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours Min. (Month, Day, Year) Pennsyl Vanja
	land DW		Usual Residence of Decedent  10a. State 10b. County 1 10c. City, Town or Location 10d. Inside City Limits
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If Item 27 is marked other than "natural, or Itams 23a or 28a-f ahow or other traumatic event, Ita Medical Examinar must be indiffied at	ctor	Pa. NA Philadelphia 1 TYes 2 No
	3a or 2	by Funeral Director	10e. Street and Number  5760 Tefferson St 19131  10g. Citizen of What Country?  USA
	er deatl	uner	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
5-0036	rai', or	1 by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:  1 Yes 2 No Specify: Specify: Specify:
215-0	in 72 ho n *natu Aedical	Completed	15. Decedent's Education (Specify only highest grade completed)  [Second only highest grade completed]  [Second only highest grade completed]  [Second only highest grade completed]  [Second only highest grade completed]  [Second only highest grade completed]  [Second only highest grade completed]  [Second only highest grade completed]
2	filed within Hygiene. other than ont, the Mer	Com	Elementary/Secondary (0-12)  College (1-4or 5+)  R  18. Mother's Name (First, Middle, Maiden Surname)
Maryland	ould be fil Mental H Marked oth	To Be	17. Father's Name (First, Middle, Maiden Surname)  18. Mother's Name (First, Middle, Maiden Surname)  18. Mother's Name (First, Middle, Maiden Surname)
Aary	2 shour and M is mar		19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	permit. Pages 1 and Depertment of Health Important: If item 27 any injury or othar tr once.		20a. Method of Disposition  20b. Place of Disposition (Name of cemelary, crematory or other place)  20c. Location - City or Town, State
Baltimore,	Pa neur par		ABurial 2 Greenation 3 Hemoval from State Rolling Green Cem, 8/31/2006 West chester Pa.
Bal	permit. Depertrimports any inject.		21. Signature of Funeral Service Licensage  22. Name and Address of Facility  1. Seph L. Russ Funeral Home, P.A.  2222 W. North Ave. Balto. Md. 21216
			23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a.   A TERIOSCLEROTIC CARPTOVASCUAR DISEASE  Due to (or as a consequence of):
÷Ş	Examiner	-	Sequentially list conditions if any, leading to immediate Due to (or as a consequence or):
/	nd transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.
8760,	eath certificate be executed attending physicien end for use as the burial-transit	dicai Ex	resulting in death) Last  Due to (or as a consequence of):
9	ntificate ing phy e as the	Medic	IF FEMALE:
Box	requires that the death certific een signed by the attending p hould be detached for use as t	Physician/Me	23b. Was decedent prefinant in the past 12 months?  1   Ves 2   Disc.   Ves outcome of pregnancy of pregnancy   23d. Date of delivery   23d. Date of d
P.O.	that the de ed by the detached	Phys	9 Unknown 9 Unknown 9 Unknown  9 Unknown  9 Unknown  23e. Did tobacco use contribute to the cause of death?
rds,	v requires that been signed I should be det	ed by	STATUS POST NEPHICATORY, TAKERA COLECTORY 1 Yes 2 No 3 Probably 4 DUNKNOWN
Division of Vital Records,	e law has b je 2 st	Completed by	24a. Was an autopsy findings available prior to completion of cause of death?
ital	ician: The l certificate harector, page	Be Co	1   Yes   2   No   1   Yes   2   No   25. Was case referred to medical   26. Place of Death (Check only one)
of V	S & D	ို	examiner?  ## Despital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Tother (Specify)  27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
ion	ttending Ph death. ctor: After th y the funeral	atlon	1 Statural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No
Divis	after de Direct	Certification:	3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospitel or Attenwihin 24 hours after deatl To the Euneral Director: completely filled in by the	ledical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the Within 2 To the comple	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day/Year)
	01		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Rope + March 1 (M) 180 + MONTH A/R DRIVE Function MD 21043
	1		Mas 1. 1110 May 1 1 May 1 1 Miles Chill Carl 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	St Regist	ate rar	31. Date filed (Month, Day, Year)  32. Begistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 27, 2006 AUGUST 4:30 P M DOONTRE JORDON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F Yrs Director 913 9P PPOI UNTATIONIE Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Mersharo 1 ☐ Yes 2 No Director BALTINORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ or itama 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 NYes 2 No HYes, Give Year or Dates: ⟨⟨⟨\$\frac{1}{2}\$\$ 1 Never Married 280 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2¶ No Specify: þ Specify: 3 Widowed 4 Divorced WHITE 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) CETATE DETUNU 12 should be filed within 7. h and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) Cotlege (1-4or 5+) 5 Origin 13782 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 500) VAULOSSE JAMES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st. Department of Health and Important: If Item 27 I am any injury or other traum 8808 AVOI 1007 ELD AGETTY 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition AUG. 31 1 € Burial 2 Cremation 3 Removal from State With I Kalla V BALLUD 4 Donation 5 ☐ Other (Specify) goop limocur 21. Sonal re of Funer II Service Licensee 22. Name and Address of Facility ELD MERIE 08123 120 Choffel oce HA ON 1824 PB UO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPTIC SHOCK /Medical Due to (or as a consequence of) Examiner RUPTURED DIVERTICULUM Sequentially list on differentially leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit RESPIRATORY FAILURE Due to (or as a consequence of): attending physician Box 68760 99 RENAL FAILURE Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown څ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š LACTIC ACID 1 Yes 2 No 3 Probably 4 Unknown LACTIC ACIDOSIS 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 24 No 24a Was an certificate has 2 X No 1 🗌 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 V Inpatient examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? Hospital or Attending After 1 Natural
2 Accident Injury 5 Pending death. 1 ☐ Yes 2 No investigation after death Diractor: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the e 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number 8-27-06 D 31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD L.LINTHICUM M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 2 9 2006

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** A. M. 2:12 LZONA 33 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GJEHRET Le/D(SE WOI If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country), **Funeral** Months Days Hours Min. 1 □ M 2 SF Yrs. 1803 Director 331 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits al Hygiene. I other then "naturel", or iteme 23e or 28e-1 errors event, ite Medical Examiner must be cotified at 1 Yes 2 No Directo MAJAM BALlinovala 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31336 8100 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: δ 3€ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Tironge Elementary/Secondary (0-12) College (1-4or 5+) TIRIP 52 RVER 8162 permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other treumssizes. other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1500222 FRAME ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1ARYLARC THOMAS JOS JAM VI 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery crematory or other place AUG. 31 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1084/ADI 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility - Paragraph (3.5) 21. 3 gn was of Funer I Service Licens 21834 MALESSAL Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final lesp votor ndrime woods **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

Yo the Funeral Director: Attent this certificate hes been signed by the ettending physicien and coxplately filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 ₹No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

AUG 2 9 2006

30. Name and address of person who completed cause of death (I)em/23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



(m)

Amend #1 Pestaten of Maryland & Pepartment of Health and Mental Hygien 2006 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** J<del>effrey L. Davis</del> 8:00 а.тм August 27, 2006 Jeffrey C. Davis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Dunda1k 1837 Church Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Davs | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 □ F 49 220-66-0236 Yrs. 1956 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes XXNo MD Baltimore Dundalk Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a or 21222 1837 Church Road filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ 3 ☐ Widowed 4 ₺ Divorced naturel Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Printing Courier year permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Constance B. Dix Veachel W. Davis, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1837 Church Road, Baltimore, MD Pamela Davis, sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Aug. 29, 2006Baltimore, MD Metro Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charles S. Zeiler 21. Sign ture of Funeral Service Licensee 6224 Eastern Avenue Baltimore, MD 21224 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYDCA RDIAL INFARCTON ACUTE /Medical Examiner · ATTHER DSCLEDATIC-ITYDEPLIENSIVE CARDIOVASGIAR DISTRE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physicien and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2 No 3 Probably 4 Unknown RDIONYOPATHY, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? (es 2 No LOW IHDL PERLIFICEMIA 1 ☐ Yes 2 ☐ No 1☐ Yes 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 ☐ №6 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Hospital Medicai 🖍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the h 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0015022 morran 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. J. Paglinaum, 621 Stemmers Run Rd., Baltimore, MD 31. Date filed (Month, Day, Year) 32. Paistrar's Signature 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 006 27212 For State Amend item#10c,19b,perFH,0858,8/31/06 Ertificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 10:20 P M 24, 2006 James Franklin Flagle Aug. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 28, 1944 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours **¼** M 2□ F 213-42-4651 62 Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County the Medical Examiner coust be notified at 1 ☐ Yes 2 X No Directo Md Harford Abington Abingdon 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code ö 1012 W. Viking Ct. 21009 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give Year or Dates: 63 1 -67 1 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify.White 1 Yes 2 No ö Specify Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Telephone/ Cotlege (1-4or 5+) N/A Elementary/Secondary (0-12) Engineer Communications 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Itam 27 Is marked oth any injury or other traumatic event 9DGs. Be Franklin Charles Flagle Anna Louise Tawney 19b. Mailing Address (Street and Number or wal Fluite Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1012 W. Viking Ct. Rose M. Flagle/Wife Abington, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. 28, 20c. Location - City or Town, State 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkville, MD Parkwood Cemetery 2006 4 □ Donation 5 □ Other (Specify) Lemmon Funeral Home of Dulaney Valley, Inc. Michael J. Flagle 10 W. Padonia Road Timonium, MD 21093 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Severe Pneumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consectionne of Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown Emphysema 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an -lagle, Franklin autopsy 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title a certifier August 24,2006 00063420 address of person who completed cause of death (Item 23a) (Type, Print) Haral, MD. 500 Upper Chesapeake Dr. Bel Air, MD 21014 Lubair 31. Date filed (Month Hay, 2 edi) 2006 State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006

		•	State Registrar	,	Cei	rtificate	e of De	eath		Reg. N	0.	•		, ,
	a		1. Decedent's Name (First, Middle, Last	)	-				2. Date of De		ay \	'ear	3. Time of	Death
	Physici /Medic		Marcelle Bosc Fel	lows					August	23,	2006		11:10	A M
	Examin		4a. Facility Name (If not institution, give			4b. City,	Town, or Lo	cation of Death		4	c. County of	Death		
***			2879 Glenora Lane				ckvil]				Montg			
	Funeral		5. Social Security Number 6. Se	TM ONTE	last birthday) Yrs.	If Under Months		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ıy, Yeai	7)	Cou		r Foreign
8	Director	5	579-44-6076  Usuat Residence of Decedent	78	115.				Jan. 8	, 19	128	Fra	nce	
	and		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation							10d. Inside Cit	ity Limits
	Mary f sho	ō	Maryland Montgome	Po	ckville								1 X Yes	2 🗌 No
	288 288	rec	10e. Street and Number	aly Rot	-KVIIIC	10f. Zip	Code			10g. C	itizen of Wh	at Cou	ntry?	-
	3 with	<u></u>	2879 Glenora Lane			20	0850			Und	ted S	tot	0.0	
	death with the Maryland me 23a or 28a-f show rmust be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Deced	ent of Hispa	anic Origin? (Sp Mexican, Puerto	ecify Yes or No		14. Race	Ameri	can Indian,	
9	after or ite	Ē	1 Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give		1 ☐ Yes 2		Specify:	rican, etc.)			White,	etc.	
93	72 hours after natural', or ite	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		10165 2	222140 2	specity.			Specify:	Whi	Lte	
21215-0036	72 h natu	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	(Give	kind of wor	l Occupatio k done duri	n ing most of work	ang	16b.	Kind of Bus	ness/in	dustry	
121	within ene. then "	mpi	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)		nemake	,			0-	n Hom	_		
7	12 should be filed within in and Mental Hygiene. 7 ie marked other then "reumatic event, the Men	ပိ	12 17. Father's Name (First, Middle, Last)		пот	пешак		Mother's Nam	e (First, Middle					
Maryland	ontall ed o	) Be	Maurice Bosc					Germaine			,			
7	should nd Me mark mati	우	19a. Informant's Name/Relationship (T	vpe, Print)	19b. Mailir	ng Address			al Route Numb	er, City	or Town, S	ate, Ziu	p Code)	
	alth ar 27 io r treu		Robert F. Fellows	/Husband	2879	Glend	ora La	ane. Roo	kville,	. Ma	rvlan	d	20850	
ē,	ss 1 and 2 should be filled within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 ie marked other then "natural", or iteme 23e or 28a-f show other treumatic event, the Medical Examinal must be notified at	1 3	20a. Method of Disposition	20b.	Place of Dispo	sition (Nam	ne of		Date		Location - C		own, State	
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alti	mit. partm porta porta / inju	i	21. Signature of Funeral Service Licens		22	2. Name and	d Address of	f Facility Rol	ert A. 00 West	Pun	phrey	Fu	neral	Home/
m	Departiment of the particular in the particular		Jail E. Le	M00	803 R	ockvi.	lle, N	laryland	1 20850	-28	itgome 805	ry	Avenue	
35			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea	th. Do not ent	er the mode	e of dying, s	such as cardiac	or respiratory a	rrest,			Approximate Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition	Pulmonary	Failur	е							Onset and I	Death
	/Medical		resulting in death)	a Due to (or as a consec										
b	Examiner		Sequentially list conditions.	Ovarian Ca										
	De sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury	Due to (or as a consec	quence of):									
	and trans	kam	that initiated events resulting in death) Last	c. Due to (or as a consec	Tuonco of):									
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68760,	icate phys s the	Medical		d										
×	certif ding se as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn	ancy						23d. Date	of deliv	rerv	
Bo	that the death c ed by the attenc detached for us	Physician	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of the	al death 3L	Ectopic pro Other (spe					Mont			Year
P.0.	that the di ed by the detached	hys	9 Unknown	9□ Unknown										
о. С	w requires that been signed to should be deta	by P	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the u	nderlying ca	ause given i	in Part I.	23e. Did 1	obacco	use contrib	ute to t	the cause of d	Jeath?
g	requires een sign	edt							1 🗆	Yes	2 <b>™</b> No 3	☐ Pro	bably 4 🗆	Jnknown
S	aw reas bee	plet							24a. Was		24b. W	ere auto	opsy findings ompletion of c	available
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ta	ilcian: Th certificate rector, pag	Be C	25. Was case referred to medical				20	6. Place of Dea	th (Check only					
	Q 50	To	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 🗆 DO	Other:	4 Nursing H	ome 5⊠ Resi	dence	6 □Other	(Speci	ty)	
0	nding Pl ath. r: After the e funera		27. Manner of Death 1 X Naturat 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		8c. Injury at Work?		28d. Describe	how in	ury occurre	1		
sio	death. ctor: Af y the fur	cati	2 Accident investigation 3 Suicide 6 Could not be			М		s 2 🗆 No	-	_				
Division of	or At fler d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, sti ify)	reet, factory	r, office		28f. Location ( City or To	Street a wn, Sta	and Number te)	or Run	al Route Num	ber,
	pitai ours a erai (	S	29a. Certifier 1 Certifying Phy	vsician: To the best of my kn	Owlodgo doot	h assured	at the time	date and place	and due to the	021150/	is) and man	205 20 6	etatod	
	o the Hospital or Attending Phithin 24 hours after death. o the Funeral Director: After the Appletely filled in by the funeral	edicai	(Check only 2 Medical Exem	iner: On the basis of examin and manner stated.	ation and/or in	vestigation,	in my opini	ion, death occur	red at the time,	date a	nd place, ar	d due t	to the cause(s	<b>;</b> )
	To the Hospital or Attend within 24 hours after death to the Funeral Director: . completely filled in by the i	Me	29b. Signature and title of certifier	~		29c	. License n	umber		29d. D	ate signed	Month,	Dey, Year)	
	1		1	2/18			D6293	8		Aug	ust 24	, 2	2006	
1	2 /		30. Name and address of person who o	completed cause of death (Ite	т 23а) (Туре,	Print)								
2	2		Jessica M. Vaught			Avenu	e #20	l, Anna	polis,	Mar	yland	214	01	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 9 20	32 registrar's Sign	ature	aste								

State of Maryland / Department of Health and Mental Hygieney 27214 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year August Giancristoforo-Smith 27 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice Gilchrist Towson Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 219-70-9882 1 ☐ M 2 ☐ F Hours 49 Yrs. Director October 9, 1956 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits and Mental Hygiene. Is marked other than "natural", or Itema 23s or 28s-f ahow sumatic avent, Its Madical Examinar roust be nutified at Baltimore 1 Yes 2 No Maryland Stevenson Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Greenspring Valley Rd 2030 USA 21153 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Account Executive Marketing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic avent <u>9DC8</u>. Philip GiancristoForo Vera Quatrini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valley Rd. Richard L. Smith 2030 Greenspring Stevenson, MD 21153 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry August 27,2006 Harover, MD 4 Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 0 Drive Suite P. Hanover, MD 21076 7522 Connelley 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER LURY Metast montes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner this certificate hes been signed by the ettending physicien and all director, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>م</u> 2 1 No 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 2 No of Vital neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient Other: 1 ☐ Yes 2 Ø No ဥ 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1-Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number August 27,200 6 25205 uso who completed cause of death (Item 23a) (Type, Print) 670 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2006 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year DO RLC 50 A M (2FO) 4 2006 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Woodbridge BALTIMORE Manor Care CATONSVILLE Valley If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex P. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗷 F Yrs. 219-12-5653 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Nedical Evaninar must be notified at 1 Tyes 2 No Directo BALTIMORE CATONSVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 MCINTOSH APT. 21228 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mentai Hydiene. important: If item 27 is marked other than "natural; or items 23a any injury or other traumatic event, the Medical Examinet must ance. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ⋧ 3 M Widowed 4 □ Divorced BIACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER 12TH GRADE WESTERN FLEET NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAMUEL MATHEWS EUA ONEIL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SISTER) APT. H. PATRICIA JULIAN 3 MCINTOSH CATONSVILLE, MO 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State ARBUMUS \* 4 ☐ Donation 5 ☐ Other (Specify) 08.30.06 BALTIMORE, MD 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BAUTO. NATU PIKE, BAUTO. MP 21229 21. Signature of Fuperal Service Licensee augh 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RELIAL ADENULARLINOMA Physician disease or condition resulting in death) METASTATIL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 1 ☐ Yes 2 ☑ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ANEMIA 1 Yes 2 No 3 Probably 4 Winknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 \ No 202 No 1 Yes 1 TYes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗜 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P D 0059107 08-28-2006 m. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS CENTER DRIVE, REISTERSTOWN 21136 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 2 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygien 0 0 6 2

Physician   Middled   Examinor   Middled			1 - For Registrar  1. Decedent's Name (First, Middle, Las	State of Mary	Cer	tificate of Dea	ath		g. No.		3. Time of Death
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Control of State   Country   Count	Funeral							8. Date of Birth (Month, Day,	(ear)	9. Birthple Count	ace (State or Foreign
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17. Father's Name (First, Modes, Assignment)   18. Mother's Name (First, Modes, Assignment)   19. Making Address (Sireal and Number or Rural Flouts Number, City or Town, State, Zip Code)	deatl	ner		12. Was Decedent Ever		Was Decedent of Hispani f Yes, specify Cuban, Me	nic Origin? (Sp	ecify Yes or No- Rican, etc.)			
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17. Father's Name (First, Modes, Assignment)   18. Mother's Name (First, Modes, Assignment)   19. Making Address (Sireal and Number or Rural Flouts Number, City or Town, State, Zip Code)	"nati	lete	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	ient's Usual Occupation kind of work done during DO NOT use retired)	g most of work	ing	50. Kind of	Business/ind	ustry
17. Father's Name (First, Modes, Assignment)   18. Mother's Name (First, Modes, Assignment)   19. Making Address (Sireal and Number or Rural Flouts Number, City or Town, State, Zip Code)	withii then	Ĕ							Н	ome	
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21. Signapure of Fungal Sarvice Licensee    March   Facility   Agrowmate   Agr	of H				Ob. Place of Dispo cemetery, crer	sition (Name of natory or other place)		Date 2	Oc. Location	n - City or Tov	wn, State
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inforcing Between Objects and Death Middle and the cause of	Pag ment ant: f		4 Donation 5 Other (Specify	()				17/06	Rand	allst	own, Md
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inforcing Between Objects and Death Inforcement Between Objects and Death Inforce	armit.		21. Signature of Funeral Service Licen	see // O	Ma Ma	Name and Address of I	Facility lest				
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25. Was case referred to medical examiner?	the death cer y the attendir iched for use	ysician/N	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No  9 ☑ Winknown  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)								•
25. Was case referred to medical examiner?	uires that signed b	ğ	Part II. Other significant conditions of	ontributing to death but no	t resulting in the u	nderlying cause given in	Part I.				1.0
25. Was case referred to medical examiner?	w rec	lete							241	o. Were autop	osy findings available
25. Was case referred to medical examiner?	he la e ha: age 2	Ę						perform	ed/3	death?	
St. Describe how injury occurred    1			25. Was case referred to medical			26.	Place of Deat	ATTENDED TO STATE OF THE PARTY		10103	20,140
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Christopher Maulucci 22 Softh Greene Street Baltinge MD 2/201	ysici is cer direc			Hospital: 1 Inpatient	2 ER/Outpatier	Other		77 - 37-5-0		other (Specify	)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Christopher Maulucci 22 Softh Greene Street Baltinge MD 2/201	ng Ph ter th			28a. Date of Injury (Month, Day Ye		28c. Injury at Work?		28d. Describe how	v injury occ	urred	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Christopher Maulucci 22 Softh Greene Street Baltinge MD 2/201	ath. or: Af	atic	2 Accident investigation	8/7/06			2 No	Subjec	t Fe	11	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Christopher Maulucci 22 S. the Greene Street Baltimere MD 2/201	r Att	Ę		289. Place of injury -	At home, farm, str pecify)	eet, factory, office		28f. Location (Streetly or Town,	et and Nur State)	mber or Rural	Route Number,
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Christopher Maulucci 22 S. the Greene Street Baltimere MD 2/201	Hosp 14 hou Fune Fune	cal	(Check only 2 Medical Exam	niner: On the basis of exa	y Knowledge, deat mination and/or in	n occurred at the time, da vestigation, in my opinior	ate and place, n, death occur	and due to the car red at the time, da	use(s) and i te and plac	manner as sta e, and due to	ated. the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Christopher Maulucci 22 S. the Greene Street Baltimere MD 2/201	thin 2 the mplet	Med		and manner stated.		29c. License nun	mber	29	d. Date sign	ned (Month, I	Day, Year)
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DA DA CHARLES DA MARIA	4/		1 ~ 1 ~ 1 / 1	1	(Helli 238) (1908,	ing street	B. Him	in MA	2/201		
	St	ate		14	Signature	alle)	201111	Q E 7.40			

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician AUGUST 25, 2008 **GOODHART** 1:25 A ELIZABETH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE PIKESVILLE 725 MT. WILSON LANE #311 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth 1913 Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🛛 F Hours 212-10-4239 92 MD Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 7 is marked other than "natural", or iteme 23a or 28a-f show traumatic event, the Modifical Examinar must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 725 MT. WILSON LANE #311 21208 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) be filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be tand Mental I COHEN WEIS BLANCHE HOWARD ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 te m any injury or other traum 2002. 6901 ROHR ROAD - BALTIMORE, MD 21209 JUDITH ZIMMERMAN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State OLD HAR SINAI CEMETERY 08/27/2006 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Matt Conn-8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Longestive weeks hec /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ner Due to for as a consequence off certificate be executed attending physicien and for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) i signed by the a Id be detached f P.O. 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Worknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? this certificate 1 Yes 1 ☐ Yes 2 ☐ No 2 110 Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 1 10 After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Matural 5 | Pending To the Hospitel or within 24 hours effer death.
To the Funerel Director: All 1 Tes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number August 25, 2006 051426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elliot Rothschild 4000 Old court Pike sville. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Comme AUG 2 & ZUUS Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Marc Rory Goldberg 2006 27218 1- For State Certificate of Death Reg No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day August 25, 2006 MARC RORY **GOLDBERG** 2128 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Tufton Avenue & Dover Road Reistertown **Baltimore County** B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** 6. Sex Months Days Hours Min Director 02/17/1988 Country) BRAZIL 216-23-8366 18 1 X M 2 Usual Residence of Decedent Oc. City, Town or Location 10d. Inside City Limits 'n 1 Yes 2 X No BALTIMORE OWINGS MILLS 28a-f show MD nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene ourtant: If item 27 is marked other than "natural", or items 23a or 28a-f sho notified at once Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12208 WOODELVES DRIVE 21117 USA Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married Yes 2 X No WHITE If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed Divorced Specify: ð Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 NONE NONE 11 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) the GOLDBERG DENISE MARLEN Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NEIL GOLDBERG / FATHER 12208 WOODELVES DRIVE - OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 BALTIMORE HEBREW CEM. 08/28/2006 REISTERSTOWN, MD or ot Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or hear **Physician** failure List only one cause on each line Retween Onset and /Medical Death a. Head Injuries Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and UNPENDED AMENDED attending physician or use as the burial Box 68760. IF FEMALE 23d Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day 2 Fetal death past 12 months? Pregnant at time of death Physici Other (Specify) 5 Yes 2 No 9 Unknown icate has been signed by the att page 2 should be detached for Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. 2 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed certificate Yes 2 V No No 26.Place of Death (Check only one) 25. Was case referred to medical or Attending Physician: Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other. Scene 1 V Yes No 28a Date of Injury (Month, Day Year) Aug 25, 2006 After 27, Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Passenger in auto collision 1 Natural 2119 hrs Yes 2 V No 5 Pending death Director: 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) Tufton Avenue & Dover Road, Reisterstown, Md. determined (Specify) Major Road / Highway 4 29a C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the one) 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 26, 2006 and address of person who completed cause of death (Item 23a) Laron Locke MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State

Registra

			For State Registrar	State of Marylar		artment of H			ene No2006	27219
			Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death
	Physici /Medic		MARIAN GROSS					August	25,2004	330 g M
	Examin		4a. Facility Name (If not institution, give s		100	4b. City, Town, or	Location of Death	141	4c. County of Death	1
			5. Social Sécurity Number 6. Sex	T. Age (In yrs	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
ľ	Funeral Director			M 2\XF 8		Months Days	Hours Min.	(Month, Day, Y	ear) Cou	t Virginia
,	DC .		Usual Residence of Decedent  10a, State 10b, County	10c C	ity, Town or Lo	cation				10d. Inside City Limits
	Aaryla Fehor	ō	Maryland Anne Arund		inthiam					1 ☐ Yes 2√No
	r 28a-	rect	10e. Street and Number			10f. Zip Code		10g	J. Citizen of What Cou	untry?
	th with	Funeral Director	416 Music Lane			21090			United S	States
	tema tema	uner	TI. Walter States	12. Was Decedent Ever in t Armed Forces?		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	is afte		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	943   .	1 ☐ Yes 2 🔀 No	Specify:		Specify: W	hite
9	within 72 hours after death with the Maryland ene. then "naturel", or itema 23e or 28e-f ehow the Madical Examinar must be notified at	Completed by	15. Decedent's Educ	cation	16a. Deced	dent's Usual Occup		16	6b. Kind of Business/li	ndustry
21	ithin 7	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	"		inancial	
12	e filed within al Hygiene. I other then "		17. Father's Name (First, Middle, Last)		Bank	Teller		e (First, Middle, Ma		
au	outd be i Mental i arked o	To Be	Raymond Foreste	er				urnside		
Maryland 21215-0036	S D E E	٦	19a. Informant's Name/Relationship (Type						City or Town, State, Zi	
	is 1 and 2 of Health a item 27 ie		John Gross- Son		W 2000 W 2000				, MD. 21	
lore	t of H if iter or of		20a. Method of Disposition  1 Burial 200 remation 3 Re	emoval from State	cemetery, cren	sition (Name of natory or other place	e)		c. Location - City or 1	
Baltimore,	permit. Pages Department of I Important: If Ite eny injury or of once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		T	Cremato . Name and Addres		6/2006	Baltimor	e, Marylan
Ba	Depa Impo eny ir		> Kathleen A	4. Weller C	FSP B	avid J. 311 Edmo	Weber Fondson A			
			23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final	cations that caused the dea	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arres	1,	Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse	quence of):					
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	אַל עַ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con		10				
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8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical E	L d		1000					
9	rtificat ng phy r as th	Medi	IF FEMALE:							
Вох	leath certific attending p I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr 1☐Live birth 2☐Fet	al death 3	Ectopic pregnancy			23d. Date of delin	very Day Year
0	at the de by the a stached f	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	4☐ Pregnant at time of 9☐ Unknown	death 5L	Other (specify)				
Δ.	requires that the leen signed by th hould be detache	by Pt	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ğ	w require been sig should b							1 🗆 Yes	2 □ No 3 □ Pro	bably 4 Unknown
Vital Records,	as b	Completed						24a. Was an autopsy	prior to o	topsy findings available omptetion of cause of
E H	Page 1		-						ed? death? No 1 ☐ Yes	2 No
	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1 Dinpatient 2[	] ER/Outpatien	nt 3 DOA Oth	er	th <i>(Check only one)</i> ome 5 □ Residen	ce 6 ☐Other (Spec	ofu)
סר	ng Phy ter thi	T :uc	27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		v at	28d. Describe how		
Sio	Attending r death. ector; After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be	1			Yes 2 □ No			
Division of	l or At efter of Direct I in by	Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec		eet, factory, office		City or Town,	et and Number or Ru State)	rai Houfe Number,
_	To the Hospital or Attending I within 24 hours effer death.  To the Funeral Director: Atter completely filled in by the funer	edicai C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my kr	iowledge, deatl	h occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	290	d. Date signed (Month	, Day, Year)
	, > P 0		In	y w		89	548		8/25/06	
1	3+1	15	30. Name and address of person who co	empleted cause of death (Ite	m 23a) (Туре,	Print) DaRy	land	Grener	ral Hos	pital
	Sta Registi		31. Date filed (Month Qay, Year) AUG 2 9 200	32. Begistrar's Sign	S A	and the same				

State of Maryland / Department of Health and Mental Hygien 2006

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			1 - State Registrar				Cen	tificat	e of L	Death			Reg. No.		•		
	300	ķē.	1. Decedent's Name (First, Midd									2. Date of De		/ Y	ear	3. Time of Deat	
	Physici /Medic		Thomas	Hanford		Griege:	T.					Augüst	25,	2006	oai	7:35 p	М
	Examin		4a. Facility Name (If not institution	n, give street and n	umber)			4b. City,	Town, or	Location of	of Death		4c.	County of	Death		
1 1		i d	Manor Care Rux	kton				T	owso	n				Bal	timo	ore	
7	Funeral		5. Social Security Number	6. Sex	7. Age (	In yrs. last bir	thday)	If Under		If Under		8. Date of Bi	rth	9	. Birthp	place (State or Fore	eign
	Director		044-10-9230	1 <b>∑</b> M 2□F		91	Yrs.	Months	Days	Hours	Min.	8. Date of Bi	21',"	1915 1	Cŏ'nr	necticut	
	ס		Usual Residence of Decedent														
	ylan		10a. State 10b. County		1	10c. City, Tow									1	0d. Inside City Lin	
	Mar Mar	to	MD Bal	Ltimore		Ва.	ldwi	.n								1 🗆 Yes 2💭	No
	17 28s	Director	10e. Street and Number					10f. Zip	Code				10g. Citi	zen of Wha	at Cour	ntry?	
	Sa o	0	13605 Allisto	on Drive				2	1013				l	J.S.A			
	Jeath The 2	by Funeral	11. Marital Status	12. Was De		er in U.S.	13, W	Vas Dece	dent of Hi	spanic Ori	gin? (Spi	ecify Yes or No Rican, etc.)	0-	14. Race -			
10	in the second se	Fur	1 ☐ Never Married 2 ☐ Ma	Armed F	2X No							Hican, etc.)		Black,	White,	etc.	
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ð	2 ho	Completed	15. Decede	nt's Education		16a.	Decede	ent's Usu	al Occupa	ation	(		16b. Ki	nd of Busin	ness/In	dustry	
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D	Hygid other	Be C	17. Father's Name (First, Middle	Last)						18. Mothe	er's Name	e (First, Middle	, Maiden	Sumame)			
<u>a</u>	ould be Mental Marked c	To B	Thomas l	J. Gri	ieger					E	thel	-		Han	ford	4	
Maryland	S should be filed withir and Mental Hygiene.  Is marked other than aumatic event, Its M.	-	19a. Informant's Name/Refation	ship (Type, Print)		19b	. Mailing	g Address	s (Street a	and Numbe	er or Aura	al Route Numb	er, City o	r Town, St	ate, Zip	Code)	
Ž	s 1 and 2 should be filed within 72 hc Health and Mental Flygiene. Itam 27 Ia marked other than "netun other traumatic event, Ita Madical		Lois G. Griege	er-wife		1	1360	)5 Al	list	on Dr	., E	Baldwin	, MD	210	13		
ē,	Hea Hea tam othe		20a. Method of Disposition			20b. Place of	f Dispos	sition (Na	me of other plac	-1	(	Date	20c. Lo	cation - Ci	ty or To	own, State	
Baltimore,	ages ont of t: # I		1 Burial 2 Cremation		n State		_	_ *			8/28	3/06	To	owson	. MI	)	
∄	permit. Pa Departmen Important: any injury				liam	į.				1		•			•		
Ba	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 li any injury or other tra ance.		4 Donation 5 Other (Specify) Hilltop Serv Corp 8/28/06 Towson,  21. Signature of Funeral Service Pensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral 1050 York Rd., Towson, MD 21204											J. 10 , 21 10 1			
-	_		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. CEREBRU VAS CULAIR THROMBOS I Due to (or as a consequence of):  Sequentially list conditions  b. Audi SYROKE												Approximate		
п			shock, or heart failure. Lis	t anky and cause on	each line											Interval Between Onset and Death	1
1	Physician		Immediate Cause (Final disease or condition resulting in death)	-a. CE	RE	-BR	OV	AS	Cu	LAU	2	MRC	M	305	15	_	
	/Medical Examiner		rooming wrooming	Due to	o (or as a	consequence	of):	2 4	_							Days.	
4		_	Sequentially list conditions,			consequence		1	=							· /	
V	ed sit	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	< □	0 (01 83 8	CONSEQUENCE	OI).										
·	and and I-tran	Examiner	that initiated events resulting in death) Last	C. Due to	n (or as a	consequence	of):										-
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	certification of the second of	Me	IF FEMALE:	220 15 100 0													
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	e de the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9∐Unk		me of death	5 🗀	Other (s)	oecity)							,	
P.0	w requires that the death been signed by the atter should be detached for u	Completed by Physicia			d 45 1 A			4. 4. 1.				oge Did	1-b			he cause of death	2
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ord	equir en s ould	ted										10	Yes 2	No 3	Prot	bably 4X Unkno	JWII
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ital	an: riffica	4	25. Was case reterred to medic	at						26. Place	of Deat	h (Check only	_/_				
>	ysic is ce direc	To B	examiner?	Hospital: 1	Inpatient	2 □ ER/Oι	utpatient	3 □ D	OA Othi	er: 4 Ni	ırsıng Ho	me 5 Res	idence	6 Other	(Specif	(y)	
Division of Vital Records,	g Ph er th ieral		27. Manner of Death	28a. Date	e of Injury onth, Day	28b.	Time of		28c. Injun Worl			28d. Describe					
<u>io</u>	ath. r: Aft e fun	atio	1 Natural 5 ☐ Pend 2 ☐ Accident Inves	tigation	anti, Day	7007)	ши	М		Yes 2 🗆	No						
vis	Atte	=======================================	3 ☐ Suicide 6 ☐ Coufe 4 ☐ Homicide deter	not be 28e. Pfac	ce of fnjun	y - At home, fa (Specify)	arm, stre	et, factor	y, office			28f. Location City or To	(Street an	d Number	or Aura	al Route Number,	
ā	s afte	Certification:	Tionnedo	Odil	uling, etc.	(Specify)						Only or 10	mi, State	,			
	spit hour: inera y fille										cause(s)	and manr	er as s	tated.			
	ne Ho	edical	(Check only 2 Medica one)	examiner: On the	basis of e	ed.	avor inv	estigation	n, in my o	pinion, dea	ITF OCCUP	red at the time	, date and	piace, an	a due t	o ine cause(s)	
To Continue of the part of the						29	c. Licens	number	1		29d. Da	te signed (	Month,	Day, Year)			
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	Regist		AUG 2 S	2006	32 Registrar's Signature												
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Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland 7 Department of Health and Mental Hygien 2006 27221 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 9:20 AM PURVIS 20 2006 Henderson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center CIFL Homewood If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Genesis 8. Date of Birth (Month, Day, 27. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 87 218.07.34 138M 2□ F Yrs. Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Itam 27 is marked other than "natural", or itema 23a or 28a-1 show other traumatic event, the Medical Examinat must be notified at Baltimon MD NA 1 XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4319 Marble death with USA Load Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If Itam 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore Gao Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Laborer & Fleetno 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Henderson Edgar Julia Hayes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen D. Johnson 825 Dartmouth Road Apt. D Balto. MD 21212 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Surial 2 Cremation 3 Removal from State ō Garnson Forest 08.28.06 Owing Mills, MD permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Dayigh C. Greene Funeral Services
THOS YORK ROAD BAITMONE MD 21212 21. Signature of Funeral Service Licensee 23a. Part : Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician Chronic Guconia nears disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Gustak Canculous to (or as a consequence of): 4 ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. by ate has been signi page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Renal 145 Alan Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No after death.

Diractor: After this certifics
J in by the funeral director, I To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled within 24 hours a To the Funaral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Wind Kley no D31795 30. Name and address person wh completed cause of death (Item 23a) (Type, Print) md 21204 2 Towson 10701 N. Charles Street Kloesz Wendy Kloesz V
31. Date filed (Month, Day, Year) Surle 4202 32 Registrar's Signature State Registrar AUG 2 9 2006

			1 - For State Registrar	State of Mary	land / Depa <i>Cer</i> t	rtment c tificate	of Health and of Death	Mental Hygie	2006	27222
	Physic /Med		1. Decedent's Name (First, Middle, Last, LEONA K HAIR	STAN				2. Date of Death Month	27.2006	3. Time of Death
	Exami		4a. Facility Name (If not institution, give SAINT AGNE.		6	4b. City, Tov	vn, or Location of Deat	h j	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Se. 213.82.1497	x 7. Age (In Q F	yrs. last birthday) Yrs.	If Under 1 Y Months Da	ear If Under 24 Hrs ays Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthr	place (State or Foreign http) VA
	tryland show		Usual Residence of Decedent  10a. State  10b. County		c. City, Town or Loc	_			1	10d. Inside City Limits
	72 hours after death with the Maryland 72 hours after death with the Maryland naturel', or Items 23a or 28a-1 show filed Examiner must be notified at	Funeral Director	10e. Street and Number	\	BALTIMORI	10f. Zip Co	de	10g.	. Citizen of What Cour	1 <b>Ø</b> Yes 2 ☐ No ntry?
	sath with s 23s o	erai D	202 N. CULVER	ST.		2	21229		USA	
g	after de or Item	/ Fune	11. Marital Status 1 ☐ Never Married 2 € Married	12. Was Decedent Ever Armed Forces? 1 Yes 2 XNo If Yes, Give	If	Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	to Rican, etc.)	14. Race - Americ Black, White, Specify:	etc.
ò	2 hours	ted by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:	16a. Decede	ent's Usual O	ccupation	166	b. Kind of Business/In	AQZ dustry
21215_0026	od within 7 giene. er then "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	ind of work di ONOT use re MEMA	_	rking	DOMEST	1C
Tack of the same o	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23s or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be (	17. Father's Name (First, Middle, Last)  MARSHALL KING	'			18. Mother's Nar	ne (First, Middle, Mai	den Sumame)	
Mon	nd 2 shi alth and 27 is m ir traum		19a. Informant's Name/Relationship (Ty	rpe, Print) J (IJUSBANI)	1	Address (St	reet and Number or Ri	BAUO.	ity or Town, State, Zip	Code)
	ges 1 and 1 des 1		20a. Method of Disposition  1 🗷 Burial 2 🗆 Cremation 3 🗆 F	Removal from State	Ob. Place of Dispos cemetery, crem	atory or other	place)	Date 200	c. Location - City or To	own, State
100	permit. Pa Department Important eny Injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens		OUDON P	ARK Name and A	ddroce of Eacility	1.06 BA	ALTO. MD	4
0	0 88E58	1	Vanotin C	4			JO. NATU	PIRE BAI	40. mp 2	229
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.		rest	was cardia.	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as a co	insequence of):					
	uted f ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	nsequence of):					
8760	icate be executed physicien and s the burial-transit	al Exa	resulting in death) Last	Due to (or as a co	nsequence of):					
y		ledical	~	d						
So Box	The law requires that the death certific.  The law requires that the death certific ate has been signed by the attending prage 2 should be detached for use as in the control of the contr	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 1	Ectopic pregn Other (specif)			23d. Date of delive Month	ery Day Year
10 h	signed by the a	<u>چ</u> ا	Part II. Other significant conditions con	ntributing to death but no	ot resulting in the und	derlying cause	e given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
HAIRSTO	law require as been si 2 should B	Completed	Cardiac Ar	rhythmic	U			24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
A 1	vician: The lavicertificate has		OS Was seen referred to martinal					performed	No 1 ☐ Yes	
工	Physicia this certi al directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	ER/Outpatient	3□ DOA	211	ath Check only one lome 5 Residence	e 6 □Other (Specif	·y)
14	Attending Physician: The ardeath. ector: Atter this certificate his by the funeral director.		27. Manner of Death  1.2 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ar) 28b. Time of Injury	28c.	Injury at Work?	28d. Describe how i		
EONA HAIRSTO	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, stree pecify)		•	28f. Location (Stree. City or Town, S.	t and Number or Rura (tate)	al Route Number,
7	Hospital 24 hours a Funeral I	Medical C	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of moner: On the basis of exa and manner stated.	y knewledge death imination and/or inve	oficialised at the	na lima, date and place my opinion, death occu	, and due to the sauc irred at the time, date	s(e) and marmer as el and place, and due to	tuted. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			1	cense number		Date signed (Month,	*
	10 mg		30. Name and address of para buttons	M/J	(Item 22a) (Tues 5	13	( 9914.	755	August	AZ, 2000 han heckley
	3		30. Name and address of pers who co	Caton Au	renue)	3/	15 more, 142	21229	Megi	heckley
Ĭ	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	,				

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AUG 2 9 2006 January 15 19

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27223

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year 24th 12:07 PM ZIARD HOSEIN 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND MEDICAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) Nov. 22, 1977 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State of Foreign Country) Trinidad, Indies **Funeral** 219-13-2324 1XM 2□F 28 Director Yrs. Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahov other treumatic event, the Medical Examiner count by notified at Parkville MD Baltimore 1 TYes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "--- any injury or other treumest- any injury or other treumestor items 23a or 3606 Melanie Road 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 ☐ Yes 2 No West Indian 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Chesapeake Research Elementary/Secondary (0-12) College (1-4or 5+) 5+ 12 Assistant Coordinator Review Inc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kamla Kalloo Shafiat Hosein ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3606 Melanie Road-Parkville, Maryland 21234 Shafiat Hosein-Father 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Dulanev Vallev 8-29-06 1 💢 Burial 2 □ Cremation 3 □ Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 8800 Harford Road- Parkville, Maryland 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) nset and Death **Physician** HEPATIC CARCINOMA 1DAYS /Medical Due to (or as a consequence of): Examiner RHABDOMYOLYSIS DAYS Coquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transit ACUTE RENAL FAILURE ding physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 XYes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Letifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number AU4176435E17412 = gnck August and address of person who completed cause of death (Item 23a) (Type, Print) GREENE ST. BALTIMORE, MD 2/201 - ROBIN ENCK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

			1 - For State Registrar	State of Maryland /	Department of Health and M Certificate of Death	lental Hygier Reg. r	<sup>1e</sup> .2006	27224
	Physic		1. Decedent's Name (First, Middle, Last	HARSY		2. Date of Death Month	Day Year	3. Time of Death
)	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give	ROAD	4b. City, Town, or Location of Death    City   Town, or Location of Death	8. Date of Birth (Month, Day, Yea	Ac. County of Death	ace (State or Foreign
	ъ	<u>.</u>	Usual Residence of Decedent 10a. State 10b. County		wn or Location	12000		0d. Inside City Limits
	ith the Ma or 28a-1	Olrecto	MANAGE BALLING 10e. Street and Number	10 snor	10. Zip Code	10g. (	Citizen of What Coun	1 ☐ Yes ②X No try?
<b>9</b>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event. I've Marical Examinat must be notified at ODGE.	Funeral Directo	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
21215-0036	"natural",	Completed by	3 ∰ Widowed 4 □ Divorced  15. Decedent's Edu (Specify only highest grad	If Yes, Give Y Year or Dates:  cation 16a  completed)	a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)	16b.	Specify: \D\	lustry
	e filed withii al Hygiene. other than vent. In a M	Be Comp	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	RODUCTION WORKS	e (First, Middle, Maid		72.00
Maryland	2 should by and Mente le marked raumatic e	ToE	19a. Informant's Name/Relationship (7)	7pe, Print) 19	b. Mailing Address (Street and Number or Rura	al Route Number, City	or Town, State, Zip	Code) 2/1/36
	ages 1 and nt of Health t: If Item 27		20a. Method of Disposition  128 Burial 2 Cremation 3 F	Removal from State	ery, crematory or other place)	28,	Location · City o To	wn, State
Baltimore,	permit. P. Departme Important any injury once.		4 □ Donation 5 □ Other (Specify)  21. ign to re-of Funeral Service Licen		22. Name and Address of Facility	100 60157 100 60157	ELLE GON	HCS/8
-	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	incations that caused the death. Do no cause on each line.  a. END STAG  Due to (or as a consequence	-0	er.	Note Ins.	Approximate Interval Between Onset and Death
58760,	icate be executed physicien and physicien and sthe burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence	rid Arthritis	ny Dise	nse	yrs yrs
P.O. Box 687	ath certif	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d. 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	h 3 ⊟Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver	ry Day Year
	w requires that the de been signed by the a should be detached for	β	Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the	
Il Records,		Completed				24a. Was an autopsy performed?	prior to com death?	sy findings available apletion of cause of
<u>X</u>	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	I a a a in a l		(Check only one)		
Division of Vital	ng Phys fter this ineral di	atlon: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation			me 5 Residence 28d. Describe how in		)
Divis	ital or Attend irs after death ral Director: / led in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, for building, etc. (Specify)	·	28f. Location (Street: City or Town, Sta	ite)	
	To the Hospital or Attendi within 24 hours after death. to the Funeral Director: A completely filled in by the fu	Medicai	29a. Certifier (Check only one)  2 Medical Exami  29b. Signature an #title #t certifier	sician: To the best of my knowledg ner: On the basis of examination ar manner stated.	e, death occurred at the time, date and place, and/or investigation, in my opinion, death occurr	ed at the time, date a	nd place, and due to	the cause(s)
•	15		Allin 1	empleted cause of death (Item 23a)	ND 29c. License number D54749  (Type, Print) House Ave D-1		Pate signed (Month, E	And the second s
wie de	Sta		ATIEN KEILL MU 31. Date filed (Month, Day Year)	32. Registrar's Signature	House Ave, D-1,	trever	ick, MU	21701
	Registr	ar	AUG 2 9 2	006 Regues St	Same of the same o			

			1 - For State Registrar		te of Ma	aryland /	-	artmen tificate			ind M		Reg. No 2	006	27225
	Physici /Medic		1. Decedent's Name (First, Mic	E,	Hul	L						2. Date of De Month	Day 15	So Year	3. Time of Death
	Examin		4a. Facility Name (If not institu	ion, give street a		2				Location o		<del></del>		unty of Death	
			5. Social Security Number	6. Sex	7 40	e (In yrs. last	hirthday)	If Under		If Under		8. Date of Bir		HRD a Birtho	lace (State or Foreign
	Funeral Director		058-16-9444	1 M 2		85	Yrs.	Months	Days	Hours	Min.	(Month, Da	ı <u>v</u> , Year)	New Y	trv)
	pug 🔉		Usual Residence of Decedent 10a. State 10b. Cour	ntv		10c. City, To	own or in	cation	,					1	0d. Inside City Limits
	Maryli f sho	tor	Maryland Howa			Ellic									1 ☐ Yes 2 📉 No
	or 28a	Directo	10e. Street and Number			DILIC		10f. Zip	Code				10g. Citizen	of What Coun	try?
	ath wi	rai	3000 North Ri					210					U.S.A		
	Items	Funerai	11. Marital Status 1 □ Never Married 2 □ M	Am	s Decedent ned Forces? ]Yes 2 🔀 i		13.	Was Deced 1 Yes, spec	lent of Hi	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	14.	Race - Americ Black, White,	
036	72 hours after death with the Maryland Insturel', or Items 23a or 28a-f show Jisal Exarcitret could be notified at	þ	3 X Widowed 4 ☐ Divord	. If Y	es, Give ar or Dates:			1 ☐ Yes 2	2∭ No	Specify:			Spi	ec <i>ity:</i> Whi	te
15-0	"natu	ietec	15. Deced (Specify only hig	ent's Education hest grade comp	leted)	1	(Give	dent's Usua kind of wor DO NOT us	k done d	uring most	of worki	ng	16b. Kind o	of Business/Inc	dustry
21215-0036	filed within Hygiene. wher then "	Completed	Elementary/Secondary (0-12	?) Col	llege (1-4or 5	5+)		maker		,			Own	Home	
	at Hyg d othe avent,	BeC	17. Father's Name (First, Midd			· · · · · · · · · · · · · · · · · · ·						(First, Middle	, Maiden Sur	name)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. item 27 Is marked other than "netural", or Items 23a or 28a-f show other traumatic event, The Modical Exal viller is and the mullified at	2	Francis Espos  19a. Informant's Name/Relatio		-41		105 Mailie	- A dd	(Ctmata			edfern U Route Numb	as City as Ta	State 7in	Corfol
Ma	and 2 st ealth and n 27 Is r		Cynthia H. Tu					-						wn, state, zip	Code)
ore,	ges 1 an t of Heal If item 2 or other		20a. Method of Disposition 1 X Burial 2 □ Crematic			20b. Place	e of Dispo	sition (Nam	ne of			ate		on - City or To	wn, State
Baltimore,	Pages tment of I tant: If its jury or o		`4 □Donation 5 □Other	(Specify)	II Irom State	Calve		Nat.		etery	<i>y</i>	700	Calver	ton, N	Y
Bal	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Servi	ce Licensee	Uni	in	K	name an Name br>Name an Name an Name an Name an Name an Name an Name Name an Name an Name an Name an Name an Name an Name an Name Name an Name an Name an Name an Name an Name an Name an Name an Name Name an Name an Name an Name an Name an Name an Name an Name Name an Name an Name an Name an Name an Name an Name Name an Name Name Name Name Name Name Name Name	Fun	eral	Home		Frank1	in Sau	11010 are, NY
8760, g	The law requires that the death certificate be executed XX is the has been signed by the attending physician and in agge 2 should be detached for use as the burial-transit	cai Examiner	shock, or heart failure. It immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	Oue to (or as	a consequence E Ster	ce of): La ce of):		f7A	avdu erte (tU	مدر	cula n	Dife	iai	Interval Between Onset and Death
9	eath certifica attending ph for use as th	/Med	IF FEMALE:	23c. If v	es, outcome	of pregnancy	,						234	Date of delive	n/
P.O. Box	that the death ed by the atten detached for u	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 4	Live birth	2 Fetal death	ath 3	Ectopic pro Other (sp	,				200.		Day Year
Records, P	w requires that been signed t should be det	by	Part II. Other significant cond	litions contributir	ng to death b	ut not resultin	ng in the u	nderlying ca	ause give	en in Part I.			obacco use o		e cause of death?
al Reco		Completed												prior to cor death?	osy findings available inpletion of cause of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to med examiner?  1 Yes 2 No	ical Hospita	l: 1 🗌 inpatie	nt 2 DED	/Outpatier	nt 3 🗆 DO	Othe			n <i>(Check only o</i> me 5 ☐ Resi		Other (Secul	4)
υot	ing Phys n. After this funeral di	n: To	27. Manner of Death		. Date of Inju (Month, Da	ry 28	b. Time of		8c. Injury Work			28d. Describe			7
sior	Attending or death. ector: After by the funer	catic	E _ Nocidon	estigation				М	1 🗆 \	/es 2 □ 1					
Division	al or At s after c il Direct d in by	Certification:		ermined 28e	building, et	ury - At home c. <i>(Specify)</i>	, farm, str	eet, factory	, office			City or To		umper or Hura	l Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier 1 Certifier (Check only one) 1 Certifier 2 Media	ying Physician: al Examiner: Or an	To the best n the basis o id manner sta	f examination	dge, deatl and/or in	n occurred vestigation,	at the tim	e, date an	d place, a	and due to the ed at the time,	cause(s) and date and pla	d manner as st ce, and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of cert	s O a	₩			290	License	3064	ĻΙ		Avg	gned (Month, I	Day, Year)  200 b
	10		30. Name and address of pers	on who complete				Print) 109	Bac	ck R	14	Neck	Road	Balt	wa Mayh
	Sta Registi		31. Date filed (Month, Day, Ye	2 9 2006	32. Registr	ar's Signature	2	ASSES.	9						

			•	For State Registrar		Sta	ite of Ma	arylan	d / Depa <i>Cer</i>	rtmen <i>tificat</i>	t of H e of l	ealth : Death	and M	ental Hy	giene Reg. No	200	16	27226
	16. ×	N 500 W		Decedent's Name (F	First, Middle,	Last)								2. Date of D Month	aath Da		eer .	3. Time of Death
_		Physicia		Eleano	or	Jane	H	edblo	m					Aug	20		006	6:55 A <sup>M</sup>
		/Medic Examin	11 ME.	4a. Facility Name (If no	at institution,	give street a	and number)			4b. City,	Town, or	Location	of Death		4c.	County of		
			(\$ <sup>1</sup> )	Suburbar	n Hosp	ital					ethe					Monte		
		Funeral		5. Social Security Num	ber	6. Sex 1 ☐ M 2		je (in yrs. i	last birthday)	If Unde Months	1 Year Days	If Under Hours	Min.	8. Date of B (Month, D	rth ay, Year)	9.	Birthpla Counti	ce (State or Foreign y)
		Director		027-22-353		1 LI M 2	IXI F	85	Yrs.					Jul 25	, 19	21		IL
	bo	3		Usual Residence of De 10a, State 10	Ob. County			10c. Cit	y, Town or Lo	cation							10	d. Inside City Limits
	SIN	ohs is	5		•			D	ockvil	16								1  Yes 2 □ No
	N ed	28a-f	ect	MD 10e. Street and Number	lontgo 	mery		I	OCKVII		Code				10g. Cit	izen of Wha	at Count	y?
	death with the Maryland	Jo of	Funeral Director	10301 Gros		Dī					0852				1	JSA		
	died	s 23	erai	10301 GFOS	svenor		as Decedent	Ever in U.	.S. 13. 1	Was Dece	dent of H	ispanic O	rigin? (Spe	cify Yes or N		14. Race -		
	Ter d	L L	'n	1 X Never Married	2 ☐ Marrie	An 1 F	med Forces? ⊐Yes 2.1270	?		f Yes, spe	city Cuba	an, Mexica	in, Puerto I	Rican, etc.)			White, e Whi	
	36	inam	þ	3 ☐ Widowed 4 [		l If	Yes, Give ear or Dates:			1 🗌 Yes	21X No	Specify	<i>/</i> :			Specify:	MILT	
	9 5	atur cal E	Completed	(015	5. Decedent	s Education	n(atad)		16a. Dece	dent's Usu	al Occup	ation	st of worki	na		ind of Busin		•
	215	Med n	pe	Elementary/Second	only highest ary (0-12)	T	ollege (1-4or	5+)				1)	st of worki			partme Gove		of Defense
	7	giene	JO.				4		Ana	alyst							Illile	
	ם פֿ	ai Hy I oth	Be (	17. Father's Name (Fil	rst, Middle, L	.ast)								(First, Middi		Sumame)		
	la la	Ment	2	Carl A. 1										r Peas				Conto
	Maryland 21215-0036	and and is mu		19a. Informant's Nam										i Route Num		or rown, Sa	ate, <i>zip</i> (	2009)
	2,	and ealth n 27		Lawrence 1		m/Nep	new	205 5	340		73.1	L., 1	NY, N	ate LVV		ocation - Ci	ty or Tox	vn. State
	ore	of H H ite	1	20a. Method of Dispos	Cremation	3 □Remov	al from State		cemetery, cre	matory or	other pla	ce)	8-23-			exandı		
	Ë	ment ant: lury o		`4 □ Donation 5	Other (Sp	ecify)		Met	tropol:	itan		( =						ral Home
	Baltimore,	parmit: Fages I after a should be given.  Important: If I fem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Fune	oral Service I	idense	BATT	10C		2. Name a 1356	W. W	elli	ngton	Ave.,	Chi	cago,	IL	60657
		5	1	23a. an. Enter the	disease, or	complication	s that cause	d the deat	th. Do not en	ter the mo	de of dyir	ng, such a	s cardiac o	or respiratory	arrest,			Approximate Interval Between
		ากงาร์เรียก		shock, or heart f		orny one cat	40.	EMIL	2									Onset and Death
Ž		/Medical	-	resulting in death)		a	Due to (or as											
Eleanor	E	Examiner		O	lisi	b. —	PN	EUN	IONIA									
3.			ner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in	nediate ving	, .	Due to (or as	s a consec	quence of):									
JA M	12	le be executed ysician and le burial-transit	Examiner	Cause (Disease or in that initiated events resulting in death) La	jury	c	5 . (											
M	0	e exe		resulting in death) La	31		Due to (or a	s a consec	quence oi):									
1	8760,	ate D hysic the bi	lica			d							,				-	
7	99	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:		00a H	yes, outcom	a of progn	2001							23d. Date	of deline	nv.
Hedblon	Вох	ath c	lan/	23b. Was decedent p		1	Live birth	2 Feta	al death 3	☐Ectopic		у				Monti		Day Year
9	0.	the a	sic	in the past 12 m 1 ☐ Yes 2 2 d 9 ☐ Unknown	No		Unknown	at time of t	ueatii St	_ Ourier (s	pacity) _							
75	<u>Р</u>	that the de ed by the detached		Part II. Dther signific	ent condition	ons contribu	ting to death	but not res	sulting in the I	underlying	cause gi	ven in Par	tl.	23e. Di	d tobacco	use contrib	ute to th	e cause of death?
16	ds,	signed be det	1 by											1[	]Yes 2	<b>№</b> No 3	☐ Prob	abiy 4 Unknown
	of Vital Records,	w requir been si should	Completed											24a. W	as an	24b. We	ere autoi	osy findings available
590	ec	elaw hast ge 2 s	npi											au	topsy rformed?		or to cor ath?	osy findings available inpletion of cause of
Š	= ,	cate pag	3											1 Yes		0 1 L	Yes	20 No
	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	ician sertifi ector	Be	25. Was case referre examiner?		Hospit	tat: V				Ot Ot	hor	1000	h Check onl		€ □ Othor	(Canaih	,)
30	of	ding Physician: The h. h. After this certificate h. funeral director, page	.T	1 Yes 2 N	lo		1 LX Inpai		ER/Outpatie		28c. Inju	4 🗆		me 5 ☐ Re 28d. Describ				7
0	L C	Jing After funer	ion	1 Natural	5 Pendir	19	Ba. Date of In (Month, C	day Year)	Injury	М	Wid	rk? ]Yes 2	□No					
90/02/6	isi	ttenc death ctor: / the	ical	2/□ Accident 3 □ Suicide	6 Could	not be	Be. Place of I	niury - At h	nome, farm, s	treet, facto	ry, office			28f. Location	(Street a	nd Number	or Rura	I Route Number,
ω	Division	or A after Direction by	Certification:	4 🗌 Homicide	determ	ined	building,	etc. (Spec	ify)		*			City or	Fown, Sta	te)		
8		To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director.		29a. Certifier (Check only	Certifyin	ng Physicial Examiner:	n: To the bes	st of my kn	nowledge, dea	th occurre	ed at the ton, in my	ime, date opinion, d	and place, leath occur	and due to the	ne cause( e, date a	s) and man	ner as si	ated. the cause(s)
		the H iin 24 the F iplete	ledical	one)			and manner	stated.				se numbe				ate signed		
		Vith To COT	Σ	29b. Signature and ti	A D or -	O.	emua.	,	i H.				660		5	2/2:	. 1	6
	7			P (	AKKO	recy	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					~ 1				100	1	-
		10		30. Name and addre		. 11							G1 00	. D. 1		o MD	20	852
ii.				Alpana G					ckvill		ce, S	oulte	GTOO	KOCH	V 111	e, MD		0.52
		St Regist	tate trar	3 240 mga (morn)		9 200		PELAR.	B	6004	20							

		FIG	State of					d Mental Hy	miene			
		For State	State 0	n iviai ytatio	•	rtificate of		a monta riy	Rea No	2006	272	27
		1. Decedent's Name (First, Midd	lle, Last)					2. Date of De			3. Time of	Death
Physic /Med		WENDY	HOFFI	MAN				AUque		24 2006	1914	М
Exami		4a. Facility Name (If not instituti	on, give street and nu	mber)	1	4b. City, Town, o	0	Death	4c.	. County of Death		
		5. Social Security Number	le. Sex	7. Age (In yrs. las	st hinthday)	If Under 1 Year	If Under 24	Hrs. S. Date of Bi	irth	9. Birth	place (State of	Foreign
Funeral Director		211-54-2752	1□M 2ÅF	46	Yrs.	Months Days	Hours	Min. (Month, D Jan. 2	ay Year) 22, 1	960 Peni	ntry) 1sylvan	-
p .		Usual Residence of Decedent  10a, State 10b, Count		100 City	Town or Lo	anting					10d. Inside Cit	v Limits
laryla   •hov	5	PA Daup:			ifax	Journal					1 🗆 Yes	
28a-1	Director	10e. Street and Number	-11	IIaı	LLan	10f. Zip Code			10g. Cit	tizen of What Cou	ntry?	
h with	O	61 Nice Road				17032	2		U.	S.A.		
ems 2	Iner	11. Marital Status	Armed Fo	edent Ever in U.S orces?	. 13.	Was Decedent of H	lispanic Origin an, Mexican, F	? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Amer Black, White		
36 s afte	by Funeral	1 ☐ Never Married 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes, Gi	ive		1 □ Yes 2🗓 No	Specify:			Specify: Whi	te	
Maryland 21215-0036 nd 2 should be filed within 72 hours after death with the Maryland lith and Mentai tytgiene. 27 ie marked other than "natural", or items 23a or 28a-f show r traumatic event, the Medical Examinar trans tea notified at	ted t	15. Decede	ent's Education		16a. Dece	dent's Usual Occup	pation	f working	16b. K	(ind of Business/l		
vithin 7:	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed) College (	1-4or 5+)	lite.	kind of work done DO NOT use retire	d)	Working				
d 21 filed wi Hygien other th		17. Father's Name (First, Middle	3		Insur	ance Ager		Name (First, Middle		surance_		
and d be findt H ed off	Be	Leonard Kiss						Adams	o, maidon			
aryla should and Men marke	2	19a. Informant's Name/Relation	0		19b. Maili	ng Address (Street		or Rural Route Num	ber, City	or Town, State, Z	p Code)	
e, Mg 1 and 2 Heelith a tam 27 is		Ronald K. Ho	fman (Hus				lalifax	, PA 1703	_			
9 5 5		20a. Method of Disposition	3 DRemoval from	cei	metery, cre	osition (Name of matory or other pla	ce)	Date 30/06		ocation - City or T		
timorial Pages thent of Brunt or or or or or or or or or or or or or		4 □Dopation 5 □ Other	(Specify)	kive		Cemetery			пат	ifax, PA		_
Baltimo permit. Page Department of Important: If eny injury or		21. Signature of Funeral Service	a Licensey	Theren		2 Name and Addre Hoover Fu 118 S Ma	ineral	Home t., Mille	rshu	ro. PA 1	7061	
		23a. Part1. Enter the disease, shock, or heart failure.	or complications that	caused the death.						-8,	Approximate Interval Bet	мееп
Physician		Immediate Cause (Final disease or condition			TINIA	L SA	ecom	A			Onset and I	Death IthS
/Medica		resulting in death)		(or as a conseque							7.7.7.	
Examine		Sequentially list conditions,	b	(or as a conseque	enes off-				-		<u>-</u>	<u></u>
ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	(5) 20 2 00.0040								
760, Ute be executed ysicien and the burial-transit	Exa	that initiated events resulting in death) Last	c. Due to	(or as a consequ	ence of):							
3760, ate be ex hysicien the buria	licai		d									
x 687 certificate ding physise as the	/Mec	IF FEMALE:	23c If yes o	utcome of pregnar	ncv					23d. Date of deli	verv	100
Box leath cert ettendin	clan	23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	1 Live	birth 2 ☐ Fetal gnant at time of de	death 3	□Ectopic pregnanc □ Other (specify) _	y		.	Month		rear
Records, P.O. Box 687  The law requires that the death certificate at the has been signed by the ettending physoage 2 should be detached for use as the	Physician/Medi	9 Unknown	9□ Unki	nown								
S, P	<b>₽</b>	Part II. Other significant cond	tions contributing to	death but not resu	Iting in the	underlying cause gi	ven in Part I.			use contribute to 2 □ No 3 □ Pro		leath? Inknown
cord w require	eted							_	-			
Aec le law has b	Completed							24a. We	opsy formed?	prior to death?	topsy findings completion of c	ause of
of Vital Records, Physician: The law requires I r this certificate has been signs ration of the control of the	ပိ	25. Was case referred to medi	cal	-	100		26. Place o	1 ☐ Yes of Death <i>Check only</i>		o 1 Li Yes	2□ No	
f Vita nysiclan: nis certifica director,	To B	examiner?	Manager	Inpatient 2□E	ER/Outpatie	int 3□ DOA O	her: 4 🗆 Nurs	sing Home 5 ☐ Re	sidence	6 □Other (Spec	ufy)	
on of ding Phy h. After thi funeral		27. Manner of Death t X Natural 5 ☐ Pen	/840	e of Injury onth, Day Year)	28b. Time Injury	We	ork?	28d. Describe	e how inju	ury occurred		
isio ttendi death. ctor: A y the fu	icati	2 Accident inve	stigation	co of loiun. At ho	me farm s	M 1 [	]Yes 2□No		(Street a	and Number or Ru	rai Route Num	iber.
Division I or Attending after death. Director: After	Certification:	4 Homicide dete		ding, etc. (Specify		root, ractory, office			own, Stat			
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director;			ying Physicien: To the									:)
the Ho iin 24 the Fu	Medicai	one)	and ma	inner stated.	ion and/or i			TOCCUTION AT THE TITLE		ate signed (Monti		
To To	2	29b. Signature and title of cert	her A				ise number	C) A				-
,		30. Name and address of pers		Use of death (Item	23a) (Type		5-00	00	HUC	GUST 21	1 2006	2
5		PALAN I APPAN	MUTHAP				OLFE	STREET.	BAL	TIMORE,	MD 21	287
	tate	31. Date filed (Month, Day, Ye	ar) 32.	Registrar's Signat		TA-						
Regis		AUG	2 9 2006	eliza.	H.	Greek ?				N 2005		
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State of Maryland / Department of Health and Mental Hygiene Reg. No 2006 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Voar **Physician** 5:50 P M 26, 2006 Richard Lee Henry August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick 9248 Waynesboro Pike Emmitsburg Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 X M 2 □ F Months Days 63 Director 185-34-2027 24,1943 PΑ Usual Residence of Decedent the Maryland 10c City Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show th and Mental Hygiene. ?7 is marked other than "natural", or Items 23a or 28a-f show treumatic event, the Medical Expiration must be notified as 1 ☐ Yes 21 No Director MD Frederick Emmitsburg 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21727 U.S.A. 9248 Waynesboro Pike death Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal. Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other trainment. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Construction Construction Inspector 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Leona Grace Hoffman Charles Henry 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9248 Waynesboro Pike Emmitsburg, Maryland 21727 Mrs. Michele Frech / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Aug. 29, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation 4 ☐ Donation 5 ☐ Other (Specify) 2006 Stevensville, MD 22. Name and Address of Facility Singleton Funeral Home, P.A. MO1120 1 Second Avenue SW Glen Burnie, Maryland 21061 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death lung Immediate Cause (Final anutas **Physician** tou m disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner nelanma Coquentially list conuntons, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ cete hes been signe page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificete 1□ Yes 21. No After this certification, funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director; completely filled in by the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, M 50 Es Kander M Elhamy 1) 31. Date filed (Month, Day Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

			State o	Maryland /	Department of H	lealth and M	lental Hygie	2006	27229
	Physici	an	Registrar  1. Decedent's Name (First, Middle, Last)	10001		Dodin	2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Fecility Name (If not institution, give street and nur	BBAI		r Location of Death	AUGUS7	24 2006 4c. County of Death	1:15 PM
3	LXAIIII	ु	400D SAMARITA	N HOSPI	TAL BA	LTIMO	RE	N/A	
100	Funeral Director		5. Social Security Number 6. Sex 215 - 22 - 2433 12M 2 F	7. Age (In yrs. last b	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo	ear) Cou	place (State or Foreign Intry)
D			Usual Residence of Decedent  10a, State 10b, County	10c City To	wn or Location		0 - 7 - 7 - 7		10d. Inside City Limits
Maryla	of eho	tor	MD BALTIMORE	100.000, 100	PARKUILL	e			1 Yes 2 No
ith the	or 28s	Director	10e. Street and Number  2 n 25 Wood Side		10f. Zip Code	2011	10g	Citizen of What Cou	intry?
death w	TOWAL	Funeral	11. Marital Status 12. Was Dece	dent Ever in U.S.	13. Was Decedent of H	34 lispanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri	
:1215-0036 within 72 hours after death with the Maryland	and Mental Hydene. Is marked other than "naturel", or Iteme 23a or 28a-f ehow sumatic event, the Medical Examinational Le notified at	by Fur	1 Never Married 2 Married 1 Yes, Gin 3 Widowed 4 Divorced Year or D	2 → No	If Yes, specify Cuba	an, Mexican, Puerto Specify:	Rican, etc.)	Specify: W	hite
5-0 72 ho	natur dicat	Completed	15. Decedent's Education (Specify only highest grade completed)	16	a. Decedent's Usual Occup (Give kind of work done	during most of work	ing 16	b. Kind of Business/Ir	ndustry
2121 awithin	than It a Ma	отр	Elementary/Secondary (0-12) College (1		life. DO NOT use retired	3)		Self	
Maryland 21215-0036	d othe	Be C	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma.	,	
arylan	marke marke	၉	19a. Informant's Name/Relationship (Type, Print)	15	b. Mailing Address (Street		30 erner		n Code)
, Ma and 2 s	it of Health and Men If item 27 is marke or other treumatic		JOAN HUBBARD		1025 Woods	ide ave	Balto M	•	
altimore,	Department of Health (Important: If Item 27 Is eny Injury or other tre once.		20a. Method of Disposition 1 ☐ Burial 2☐ Cremation 3 ☐ Removal from	comet	of Disposition (Name of ery, crematory or other place	١ ا ١		c. Location - City or T	own, State
Baltin permit. Pa	oartmer sortant lojury		4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licensee	BHUV	22. Name and Addre	ss of Facility	, Home PI	Alto. Ms.	
Ö Š	9 = 9		Yaul M. Stella		7577 hase	ord by	BA 1.72.1000	01931	
			23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on Immediate Cause (Final	ach line.		ig, such as cardiac	or respiratory arrest		Approximate interval Between Onset and Death
/i	Medical		disease or condition resulting in death)  a  Due to	OF EUM or as a consequence	e of):				
Ex	caminer	_		EBRO or as a consequence	VASCULA	RA	CCIDE	N7.	
2 - Ba	dansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	57 23 2 55736QU61106	o ory.				
8760, ate be exec	sician and burial-transit	I Exa	ne no deline de la la matera il ne ma	or as a consequence	e of):				
687 Ificate t	g physician as the buria	edical	d						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed	ed by the attending pl detached for use as t	by Physician/Me	in the past 12 months?	come of pregnancy irth 2 Fetal deat ant at time of death own	th 3 Ectopic pregnancy 5 Other (specify)	,		23d. Date of deliv Month	rery Day Year
S, P	igned b be deta	by Pt	Part II. Other significant conditions contributing to de	ath but not resulting	in the underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ord	been si	eted						2 No 3 Pro	
Division of Vital Records, I or Attending Physician: The law requires the	ate has page 2 s	Completed					24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
Vita vician:	certific rector,	Be	25. Was case referred to medical examiner?		Outpatient 3C DOA Oth	05	h (Check only one)		-
of g Phys	this neral di	n: To	27. Manner of Death 28a. ate	npatient 2 ER/C of Injury 28b. th, Day Year)	Dutpatient 3 DOA  Time of 28c. Injury Wor	4 🗀 110131119 110	me 5 Residence 28d. Describe how	e 6 Other (Speci injury occurred	fy)
SiOr tendin	death. stor: Afr / the fur	catlo	Z Accident investigation		M 1 🗆	Yes 2 □ No	201 1 - 11 (0)		
Divi	s after of Direct of in by	Certification:	dotorminad 289, Place	of injury - At nome, ing, etc. (Specify)	farm, street, factory, office		City or Town, S	at and Number or Rur State)	al Houte Number,
• Hospite	within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier Check only one)  Check only one)  Certifying Physician: To the band maning and maning the control of the contro	best of my knowledgasis of examination a ner stated.	ge, death occurred at the tir and/or investigation, in my o	me, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To th	To the comp	M	29b. Signature and title of certifier  Marusho Bah	IM, Q	29c. Licens	e number	29d	Date signed (Month)	Day, Year) 4 2006
	5		30. Name and address of person who completed cause MANISHA BAHL 31. Date filed (Month, Day, Year)  32. R	e of death (Item 23a	(Type, Print) 560	1 LOCH	RAVE	V	4 2006
146	Sta	ite	31. Date filed (Month, Day, Year) 32. A	egistrar's Signature	LEVARD,	15A L71	MORE,	IVIAKYLA	ND
C. I.	Registi	ar	AUG 2 9 2006   A	Mas Do	Marke				

			1 - For State Registrar	e of Maryla		artment of F		lental Hyg	iene g. No. 2008	27230
	Physicia /Medic		Decedent's Name (First, Middle, Last)     JAMES	E. 1	HART,	JR.		2. Date of Deal Month AUGUST		3. Time of Death
Jr.	Examin		4a. Facility Name (If not institution, give street as HOSPICE OF BALTIMORE		CENTER	•	r Location of Death		4c. County of De	ath .TIMORE
	Funeral Director		5. Social Security Number 6. Sex X M M 20		i. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 08-15-	9. Bi 1940 M	ithplace (State or Foreign Sountry) IARYLAND
	aryland ehow	1	Usual Residence of Decedent  10a. State 10b. County  MD. BALTIMORE	10c. C	City, Town or Lo		WSON			10d. Inside City Limits 1 ☐ Yes 2 XNo
	death with the Maryland ms 23a or 28a-f ehow	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	Country?
	r death w tems 23a	Funerai	Arm	Decedent Ever in led Forçes?	U.S. 13. V		21204 dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	U. S.  14. Race - Am Black, Wh	rerican Indian,
12-0036	hours after urai', or ite	by	3 Widowed 4 Divorced Yea	Yes XX No es, Give r or Dates:	,	Yes 2XXNo	Specify:		Specify:	WHITE
-כוצו	be filed within 72 hours after death with the Marylan Hygiene. Hygiene. de thystiene. Activities of the than "natural; or items 23a or 28a-f show event, the Madical Examiner must be notified at	Completed		eted) ege (1-4or 5+)	(Give	lent's Usual Occup kind of work done DO NOT use retired FOREMAN	during most of work d)	ing	16b. Kind of Busines PLASTICS	s/Industry COMPANY
and z	I be filed voted Hygie ad other fewert, III.	Be	12 YEARS  17. Father's Name (First, Middle, Last)  JAMES E.	HART,	SR.	T OKE III	18. Mother's Name			
Mary	os 1 and 2 should be of Health and Mentel iftem 27 Is marked (rother traumatic even	7	19a. Informant's Name/Relationship (Type, Prin JUDITH T. HART (WII	1)	19b. Mailin	*	and Number or Run	al Route Number	City or Town, State,	
ບ໌ ບໍ	Pages 1 and nent of Health int: If Item 27 iry or other tr		20a. Method of Disposition    X  Burial 2	20b.	Place of Dispo- cemetery, cren		(ec)	Date	20c. Location - City of	
Baltimor	permit. Pages Department of I Important: if it any injury or o once.		21. Signature of Funeral Service Licensee	(R. G.RUTI		. Name and Addre		HOME, I	1050 Y NC. TOWSON	ORK ROAD ,MD.21204
	Physician /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	that caused the dea a on each line.  When to (or as a conse	Q C	er the mode of dyin		or respiratory arm	est,	Approximate Interval Between Onset and Death
8/60,	cate be executed by sicien and the burial-transit	dicai Exa	that initiated events	ue to (or as a conse	quence of):					
O. Box &	ath certific ttending p or use as	Physician/Med	in the past 12 months?	es, outcome of pregr Live birth 2 □ Fet Pregnant at time of Unknown	tal déath 3 🗌	Ectopic pregnancy Other (specify)	1		23d. Date of d Month	elivery Day Year
ras, P.	es that gned b	Ď	Part II. Other significant conditions contribution	to death but not re	sulting in the ur	nderlying cause giv	ren in Part I.			to the cause of death?  Probably 4 Honknown
Hecord	<b>sician:</b> The law requir certificete hes been si irector, page 2 should	Completed						24a. Was a autops perform	ned2   death?	autopsy findings available completion of cause of
Vital	Physician: rthis certific ral director,	To Be C	25. Was case referred to medical examiner?  1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐	☐ ER/Outpatien	t 3 DOA Oth	26. Place of Deat	h (Check only on		acity) (A. J. a. />
DIVISION OF	To the Hospital or Attending Phys within 24 hours elited death. To the Funeral Director: Aller this completely filled in by the funeral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at		ow injury occurred	ecity) Hospica
Ë ⊃	ital or Att rs efter d at Direct	Certification;	3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - At I building, etc. (Spec	home, farm, stre cify)	eet, factory, office		28f. Location (SI City or Town	reet and Number or F n, State)	Rural Route Number,
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	10		30. Name and advess of person who complet	cause of death lite	эт (За) (Туре,	Print)	Charle	St. K	Salto Mo	121205
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 9 2005	32 Registrar's Sign	nature	esti				

		•	For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of H tificate of	łealth and I <i>Death</i>		iene 00	6 27231
			Decedent's Name (First, Middle, Las	it)				2. Date of Dear	h	3. Time of Death
	Physici /Medic		Marguerite Clain	re Hall				August	26 200	8:00 P M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	h	4c. County of I	
			10521 Samona Roa			Cockeys			Baltim	
п	Funeral		5. Social Security Number 6. S	DM akte	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
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	yland		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	a-fel	ctor	MD Baltimor	re Cock	eysvi <sup>*</sup>	l le				1 ☐ Yes 2 💢 No
	or 28	Olre	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	it Country?
	within 72 hours after death with the Maryland ene. then 'rratural', or iteme 23a or 28a-f ehow in Madical Examera mun be malified at	Completed by Funeral Director	10521 Samona Roa			21030			USA	
	er de	nne	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of F f Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- lo Rican, etc.)		American Indian, White, etc.
36	rs aft	P, F	1 Never Married 2 Married  3 X Widowed 4 Divorced	1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:		1□Yes 2以No	Specify:		Specify:	white
21215-0036	2 hou	Ped	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busin	
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yla	a Men narke	2	David Johnson	E Dist	105 14-15			Hassell	O'1 T G1-	4- 7- 0-4-\
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Iteme 23s or 28s-f show ery injury or other traumatic event, this Mudical Examination and be mailfied at once.		19a. Informant's Name/Relationship (7	1 3N 160 AD	10	•		ural Route Number CKeysvill		
6	Heal Heal tem 2		Suzanne Hall / 20a. Method of Disposition	daughter 206. P	lace of Dispo	sition (Name of			20c. Location - Cit	
Baltimore,	ages ant of nt: if i	- 8	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 3 ☐ Other (Specify	Removal from State		natory or other pla Service C		28/06	Towson.	MD
ij	ortar		21. Signature of Fune al Provice / icon		-	. Name and Addre		20/00	1050 Yo	
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_	nifical ng phy as th		IE FEMALE.							
Вох	th cer tendir or use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna		Ectopic pregnanc	1		23d. Date o Month	f delivery Day Year
Ö.	the at	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at time of do 9☐ Unknown	eath 5	Other (specify) _			Month	Day 16ai
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sio	ttendi death. ctor: A y the fu	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
Division of Vital Records,	after death after death Director:	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, far <i>m</i> , str /)	eet, factory, office		28f. Location (Si City or Town	reet and Number on, State)	or Rural Route Number,
1	To the Hospitel or Attend within 24 hours after death To the Funeral Director; completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	wledge deat	occurred at the ti	me, date and place	and due to the o	ause(s) and manne	er as stated
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	To th withir To th comp	Me	29b. Signature and title of certifier	1		29c. Licens			9d. Date signed (A	
			* **	YND		Do	026575		08-28-	2006
	9		30. Name and address of person who						.02	
			31. Date filed (Month, Day, Year)	G, MD 10155	YORK	KD COCH	EYSVILLE	E, MD Z	1030	
35.	Sta Registr		AUG 2 9 2	32. Fegistrar's Signa	& A	rade				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 705AM JONES AUGUSI 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE NA GOOD SAMARITAN NURSING CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕱 F 86 Maryland 213-18-0997 Director January 29, 1920 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinational be indiffied at Wes 2 □ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 USA 124 W. Franklin Street APT. 140 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7; h and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Nurse Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Powell Young Fannie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Poplar Grove St. Baltimore, M.D 21216 Godson (P.O.A.) 1016 permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra-Melvin Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry August 25,2006 Hanover, MD 4. □ Oonation 5 □ Other (Specify) 22. Name and Address of Facility Andrew Gifts Registry 21. Signature of Funeral Service Licensee 3 7522 Connelley Drive suit P. Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine for use as the burial-transit signed by the attending physicien end d be detached for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 🗷 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by Parkinson's Disease, Chronic Renal Insu 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 A Unknown been si Chronic atrial fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospitel or Attending Phyeician: The law within 24 hours after death.
To the Funeral Director: After this certificete has I completely filled in by the funeral director, page 2 s autopsy performed 1□ Yes 2 No 1 Yes 2 No of Vital 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification; Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Associate Medical Direct 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H64398 AVENUST 25, 2006 m Goxl Sam Nousing Center completed cause of death (Item 23a) (Type, Print) 3 BACIMORE, MD 21239 5601 LOCH RAVEN BLVD CHANG, D 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 27233 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Anna Elizabeth 26, Jacobs August 2006 4:42 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore. Gilchrist Center Towson 8. Date of Birth (Month, Day, Nov. 30 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** ,1922 Months Days Hours 1 □ M 2 🛛 F 216-16-8880 83 Vrs Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location itame 23a or 28a-f ehov th and Mentel Hygiene. 27 is marked other than "natural", or itame 23a or 28a-f ehov treumatic event, the Madical Examinar must be notified at 1 Yes 2 No Maryland Baltimore Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5138 Terrace Drive 21236 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 No Specity: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be (First Name Unknown) Freund Louisa (Surname Unknown) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard Jacobs 30 Far Corners Loop, Sparks, MD (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery Baltimore, Maryland 8/29/2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 a. Juan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** sears disease or condition resulting in death) /Medical Due to (or as a oon sequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 🔲 Unknown sete has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 PNo 3 ☐ Probably 4 ☐Unknown 1 Tes concen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificete has 2 1 No 1□ Yes After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the numerous after death.

You the Funerel Director: Af death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the P 29b. Signature and tytle of certifier 29d. Date signed (Month, Day, Year) und 30. Name and address of person. eted cause of death (Item 23a) (Type, Print) 0 Charles J. Balto Md 2,20% 6701 31. Date filed (Month, Ball Year) 22 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006

			State Registrar	State of Ma	•	Certificate of		Reg	3. No.	
	Physici		1. Decedent's Name (First, Middle, Last)  FRANK L. JENNIN	GS JR.				2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give sti Saint Joseph M	reet and number)	Center	4b. City, Town, or	Location of Death		4c. County of Deat	
	Funeral Director		5. Social Security Number 6. Sex		(In yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )	9 Birt	hplace (State or Foreign untry) RYLAND
	land Dw		Usual Residence of Decedent  10a. State 10b, County		10c. City, Town o	or Location				10d. Inside City Limits
	a Mary	ctor	MD HARFORD		FALLS	STON				1 ☐ Yes 2 MNo
	th with the 23a or 28	Funeral Director	10e. Street and Number 3001 SUFFOLK LA	NE		10f. Zip Code 2104	7		g. Citizen of What Co JSA	untry?
030	be filed within 72 hours after deeth with the Maryland tal Hygiene. Id other then "natural", or Itams 23a or 28a-f show avent, Ita Madical Examinar could be notified at	þ	11. Marital Status 12  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1- Yes 2 □ No If Yes, Give Year or Dates:	0	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 전 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: WH	e, etc.
21212-0036	within 72 ho iene. r then *natur	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)		(9	ecedent's Usual Occup Give kind of work done ife. DO NOT use retired FIONAL AC	during most of work d)	ing I	6b. Kind of Business/ HEALTH II BLUE CRO	NSURANCE
ממ	should be filed within of Mental Hygiene. marked other then amatic avent, to he	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	aiden Sumame)	
Maryland	Mental	To	FRANK L. JENNIN		405.4	Mailing Address (Street	HAZEL I		O't T Ot-1 '	The Court of
Z Z	s 1 and 2 should I Health and Mer Itam 27 is marks other traumatic		19a. Informant's Name/Relationship (Type HARRIET E. JENN			Ol SUFFOL			*	
altimore,	Pages 1 ar nent of Hea nnt: If Itam ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	20b. Place of Commetery,	Disposition (Name of crematory or other place MOUNT	(e)		BALTO • C	
Balt	permit. Pages Depertment of Importent: If It any Injury or once.		21. Signature of Fungral Service Licensee	wist		22. Name and Addre HENRY W. 16924 YO		S & SONS	S CO.	1.
	Physician		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused cause on each line	θ.	t enter the mode of dyin	ig, such as cardiac	or respiratory arres	st.	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)							
,	sxecuted and al-transit	Examiner	Sequentially list conditions, any beating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a						
68/60,	rificate be executed ng physicien and sas the burial-transit	Medical	d.							
О. Вох	The law requires that the death cert. Ne has been signed by the attending bage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	,		23d. Date of del Month	ivery Day Year
7	quires that n signed by uld be deta	ρ	Part II. Other significant conditions cont CORONARY ARTERY DI	,	it not resulting in t	he underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
II Kecords,		Completed						24a. Was an autopsy performe	prior to d	atopsy findings available completion of cause of
or Vita	Attanding Physician: The reasth. sctor: Atter this certificete by the funeral director, pag	n: To Be	27. Manner of Death	espital: 1 All patier 28a. 1 te of Injun (Month, Day	y 28b. Tir		er: 4 Nursing Ho	h (Check only one) ome 5 Residen 28d. Describe how	ce 6 ☐Other (Spec	cify)
Division of Vital	l or Attending after death. Director: After in by the funer	ertification:	1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined		ry - At home, farn		Yes 2 □ No	28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical C			examination and/	death occurred at the tir or investigation, in my o				
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	~	<u></u>	29c. Licens D 30	e number 263	290	d. Date signed (Monti	
10	74		30. Name and address of person who con FRANCIS KHOO M. D		oath (Item 23a) (T		SON MARY	YLAND 21	12014	
1.000	Sta Regista		31. Date filed (Month, Day, Year)			ede				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 23b per doc 8870 8-23-07 vt.
State of Maryland 7 Department of Health and Mental Hygiene 006 27235 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (Fig. 2. Date of Death Month Year 2:05PM 4,2006 4a. Facility Name (If not institution, give street and number) 4b. City, Jawn, or Location of Death 4c. County of Death DIA 0 ton Chera -CP mare Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Months Days Hours 1 XM 2□ F 4 Yrs 212-60-3691 maurland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 XYes 2 □ No ma 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: 14. Race -Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: and 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) militar 12th Navy para 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd wite 21225 64 ecton Dartound 2 onne 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 12 urial 2 gremation 3 Removal from State -1-06 owens mills, ma, 4 □ Donation /5/□ Other (Specify) Forciot vet. Juneral Strvice Lice 22. Name and Address of Facility FredHILTON F 23a. Pann in or the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, heart failure. List only one cause on each line. Brito ma Tomo Approximate Interval Between Onset and Death tmmedia Cause (Final disease of condition resulting in death) Head and Neik Cancer Due to (or as a consequence of): Prostate Cancer Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1. Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

28

Room 20127 Balkmore, MD 420)

/Medical Examiner law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. the Hospital or Attending Physician: nin 24 hours after death. the Funeral Director: After this certifice

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

ö Items 23a

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permit. Peges 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural; any Injury or other traumatic event, ILS Medical Exa

Priysician

ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit

certificate has

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

Be

Certification:

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Can Ilyus

30. Name and address of person and completed cause of death (Item 23a) (Type, Print)

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AUG 29

other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

State

within 24 hours a To the Funeral L

2

Registrar

DHMH 17 Rev 1/2001

N. Greene Street

32. Registrar's Signature

**ORIGINAL** 

		1	State of Maryland / Department of Health and Measurement of Death	R	eg. NZUUb	27236
П	Physicia		Decedent's Name (First, Middle, Last)	2. Date of Deat Month	Day Year 23 2006	3. Time of Death 6:40 A. M
	/Medica	al -	Mary Jericek  1. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	August	4c. County of Deat	
	Examine	er "	Morningside House of Friendship Hanover		Anne A	
, [	Funeral	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Year 11 Under 2 Year 11	8. Date of Birth (Month, Day Nov 18	Year) 9. Bin Co	hplace (State or Foreign buntry) ry Land
	Director	ī	Sual Residence of Decedent	1107. 10	, 1,00 1.0	10d. Inside City Limits
	ryland		0a. State 10b. County 10c. City, Town or Location			1 Yes 2X No
	8a-fs	ecto	laryland Anne Arundel Hanover  Oe. Street and Number 10f. Zip Code		10g. Citizen of What Co	ountry?
	with the	D.	7548 Old Telegraph Road 21076		U.S.	
30	filed within 72 hours after death with the Maryland it Hygiene. It Hygiene. In the Mactical Examiner must be nutified at yent, the Mactical Examiner must be nutified at	by Funeral Directo	1. Marital Status  1. Marital Status  1. Marital Status  1. Was Decedent Ever in U.S. Armed Forces?  1. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert In Yes, Sive Year or Dates:  1. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puert In Yes, Sive Year or Dates:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi Specify: Wh	e, etc.
215-0036	2 hour		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work	rking	16b. Kind of Business	/Industry
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2 0	filed within Hygiene. other than ent, the Mas	e Co	7. Father's Name (First, Middle, Last) 18. Mother's Name		Maiden Sumame)	
lan I	uid be Aental rked c	ToB	James Jeffeek	a Lenc	O' - T - Ctata	Zin Codo)
Maryland	2 sho		19a. Informant's Name/Relationship (Type, Print)  M. Rosann Anderson / niece  19b. Mailing Address (Street and Number or Richard Number)  229 Canal Park Drive		Salisbury	, MD. 21804
altimore, n	permit. Pages 1 and 2 should be filed within Department of Healith and Mantal Hygiene. Importent: If item 27 is marked other than "any injury or other treumetic event, the Max once.	-	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Method of Disposition (Name of cemetery, crematory or other place)  20d. Method of Disposition (Name of cemetery, crematory or other place)	Date 5/2006	20c. Location - City o	
HI I	nit. Partmer sartmer cortent injury		21. Signature of Funeral Service Licensee	Gonce Fur	neral Servi	
ñ	Dap Gany		June Mysmusoush 4001 Ritchie High			yland 21225 Approximate
В	Physician		23a. Part 1. Enter the disease, or comprigations that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	c of fespitatory at	nest,	Interval Between Onset and Death 5 1/5A 125
	/Medical Examiner		Due to (or as a consequence of):			/
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1	suted ansit	Examiner	Cause (Disease or injury			
ó,	icate be executed physician and sthe burial-transit		resulting in death) Last Due to (or as a consequence of):			
8760,	icate b physic s the b	dica	d			
). Box 6	e death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown  3 Ectopic pregnancy 5 Other (specify)		23d. Date of d Month	elivery Day Year
P.0	that the ed by detac		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	tobacco use contribute	
rds,	n sign	ed by		10	Yes 2 No 3□	Probably 4 Dunknown
Vital Records,	The law requires ate has been sign page 2 should be	ompieted		24a. Was auto perfo 1 \( \text{Yes}	psy prior to death	autopsy findings available o completion of cause of ? es 2 \square No
ital		Be C	examiner?	eath Check on	_	Assisted
of V	phys this al dii	2	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing  27 Manner of Death 28a, Date of Injury 28b, Time of 28c, Injury at	DV.	idence 6 \( \text{Other (S)}\) how injury occurred	Decry Living
On	ding After fune	ation	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No			
Division	f or Attendi after death Director: A	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location ( City or To	(Street and Number or own, State)	Rural Route Number,
	bours and numbers of the filled	edical Cer	29a. Certifiler (Check only (C	ce, and due to the curred at the time	e cause(s) and manner , date and place, and c	as stated. ue to the cause(s)
	To the H within 24 To the For	Med	one) and manner stated.  29b. Signature and title of pertifier 29c. License number		29d. Date signed (Mo	/
	->=°		1 Ruhad 21 JMD DO25 19		Hugust	75 06
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  [ZICHARD Z FISHEIZ (RAN TOWER)	S GLE	N BURNI	EMB
	S	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature			
	Regis	trar	AUG 2 9 2006 Region & Breeks			

DHMH 17 Rev 1/2001

ORIGINAL

Registrar DHMH 17 Rev 1/2001 2006

AMEND ITEM#20b.c. \$22. perFH. \$259.9/6/06. WS Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #9,10g,15,16a&b,17,18&19a&b. Per Ana Bd. \$25,060 JH Hygiene 1- Stata Registrer

1- Stata Registrer

Amend Items 23a,29c,30 per Dr. Verib, \$258,68/29/06. HB Hygiene 2006 For A Stata Registrer 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** August Grace Kindell 2006 /Medical City, Town, or Location

Batt Mae

Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)

Sep 18, 19: 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner ragnes 9. Birthplace (State or Foreign Country) unk 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖾 F 1934 71 Director 213-46-6128 Usual Residence of Decedent or 28a-f show a notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ty⊡Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code unkor then "natural", or items 23a or the Medical Examiner must be a USA 3330 Wilkens Ave. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced black 16a. Decedent's Usual Occupation
(Give kind of work done during most of working unk
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) factory worker western auto 9 unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Henry Kindell Addell Elizabeth Parson 199. Mailing Address (Street and Number of Rural Route Number, Sity of Tewn, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) ZeIda AII/daughter Health Itam 27 i Baltimore, MD 21229 900 Caton Avenue Saint Agnes Hospital Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Depertment of He
Important: If itse
eny injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ♥Other (Specify) in state MT. CARMELL 9-8-06 DUNDALK, MD. Funeral Service Licensee Ronald Service 22. Name and Address of Facility WESLEY CHAVIS JR. 2007 EASTERN AVE. 21. Signature of Funeral S ade State Anatomy Baltimore, MD BALTIMORE, MD. 21231 my 23a. Part i Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAS **Physician** LO MINUTES disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient DOA ဥ o this After thi Division o 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how insury occurred Certification; 1 Natural 5 Pending To the Hospitei or Assertion, within 24 hours efter death.

To the Funerel Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tell Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29c. License numbe **D63941** 29d. Date signed) (Month, Pay, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nilantha L. Dharshana, M.D., St. Agnes Hospital 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 9 2006 Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death		Reg. No 2006	27239
	Physici /Medi		1. Decedent's Name (First, Middle, Last)  John T. Kerr	2. Date of De August	25°, 2006°	3. Time of Death 9:15 am
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, Blakehurst Towso	or Location of Deat		<sub>ath</sub> timore
	Funeral Director		157-U1-2887 12 89 Yrs.	Hrs. 8. Date of Bin Min. (Month, Da NOV 11	9. B ay, Year) 1916 Per	rthplace (State or Foreign Country) INSYLVANIA
	Maryland a-f show ffied at	tor	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   MD   Baltimore   Baltimore			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	th with the 23a or 28a	<b>Funeral Director</b>	10e. Street and Number 10B Armagh Drive 21212		10g. Citizen of What C	country?
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantral must be notified at once.	þ	If Yes, Give 1 ☐ Yes 2 ☐ KNo Specify: Year or Dates:	? (Specify Yes or No uerto Rican, etc.)	Crasifu	
Baltimore, Maryland 21215-0020	vithin 72 ho ne. han "netura e Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 4  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  General Contraction		16b. Kind of Busines	
and 2	d be filed wantal Hygier ed other ti	Be	17. Father's Name (First, Middle, Last)	Name <i>(First, Middl</i> e izabeth	, Maiden Surname)	(ell
Mary	ind 2 should alth and Me 27 is mark	P.	19a. Informant's Name/Relationship (Type, Print)  William M. Kerr, II—son  19b. Mailing Address (Street and Number of the Name	r Rural Route Numb	er, City or Town, State,	
imore,	Pages 1 an unent of Heamant: If item		20a. Method of Disposition  1 Burial 24 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetary, crematory or other place)  Hilltop Serv Corporation	Date 8/28/06	20c. Location - City o	
Balt	permit. Departinoportinoportical		21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of FacilityRu 1050 York Rd.,	uck Towso Towson, M	n Funeral H D 21204	lome, Inc.
	, Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care shock, or heart failure. List only one cause on each line.		rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Whygestive Heavy Faruby  Due to (or as a consequence of):	e		ys
Ţ	executed n and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.			3
x 68760,	ertificate be executed Jing physician and se as the burial-transit	Medical	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):			
P.O. Box	that the death ce ed by the attendi detached for use	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		V	e to the cause of death?
ds, P	w requires that i been signed by should be deta	þ	Dimention	_		Probably 4 Unknown  Were autopsy findings
Recol	he law req e has beer age 2 shou	Completed	Denentia		rmed?	available prior to completion of cause of death?
Vital	ician: T sertificat ector, pa	Be	axaminer?	Death (Check only o		10.163 20.10
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. After this certificate has been signed by the attendit of the tuneral Director. After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	ation: To	1   Yes 2   No   No   No   No   No   No   No		dence 6 □Other (Spenow injury occurred	ecify)
Divis	tel or Atter is after dec al Director led in by th	Certification:	3 ☐ Sulcide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location ( City or Tox	Street and Number or F vn, State)	ural Route Number,
	To the Hospitel within 24 hours To the Funeral completely filled	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placed in the composition of the basis of examination and/or investigation, in my opinion, death or and manner stated.	ace, and due to the ccurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
)	To the I within 2 To the I Complei	×	29b. Signature and title of certifier  My 13 24 3 3	3	29d. Date signed (Mon	th, Day, Year) 5, 200 6
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  M MM MN (F3 M (70) N CHARUS 5	T BA	ofigure 2	MD 21204
4	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature			

			For State Registrar	State of Marylan	d / Depa	artment of F	Health and Death	Mental Hy	giene Reg. No.	2006	27240
- u'	Di-	英音	1. Decedent's Name (First, Middle, Last	O .				2. Date of De		Year	3. Time of Death
	Physici /Medic		Sara Lillian	Mahoney		Long		August	12,	2006	1/20pm
-	Examin		4a. Facility Name (If not institution, give				or Location of Deal	h		ounty of Death	
-	Funeral	ESQ.	Lorien Nursing Ho  5. Social Security Number 6. Se		last birthday)	Columbi If Under 1 Year	If Under 24 Hrs	8. Date of Bi	rth	ward 9. Birthp	place (State or Foreign
	Director		221-07-1429	□M 2ŬF 88	Yrs.	Months Days	Hours Min.	April 1	2, 19	18 Cour	PA PA
	and **		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	0d. Inside City Limits
	Maryl -f eho	ţŏ	MD Howard	Cc	lumbia	a -					1 Yes 2 XNo
	th the	irec	10e. Sireet and Number			10f. Zip Code			10g. Cilize	on of What Cour	ntry?
	ath wi	Funeral Director	6336 Cedar Lane			21044			USA		
	temet teme	nne	11. Marital Status 1 ☐ Never Married 2 ☐ Married	<ol> <li>Was Decedent Ever in U. Armed Forces?</li> <li>Yes 2 No</li> </ol>	.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	0- 14	I. Race - Americ Black, White,	
920	urs aft	ρ	3 ∑ Widowed 4 □ Divorced	If Yes, Give Year or Oates:		1□Yes 2XINo	Specify:		5	Specify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or itema 23a or 28a-f ehow na Madical Exertiner raist be notified at	Completed	15. Decedent's Edi (Specify only highest grad		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo	rking	16b. Kind	d of Business/Inc	dustry
121	vithin ne. hen	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire utive Se			F1	ectroni	05
q 5	filed v Hygie Afher t		12 17. Father's Name (First, Middle, Last)		Exec	utive se		me (First, Middle			CS
lan	lid be lental rked o	To Be	Alfred Rittenho	ouse Mahoney			Lillian	Wetheri	11 Sw	eeney	
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "natural", or itema 23a or 28a-f show aumatic event, in a Madical Exercities or ast be notified at		19a. Informant's Name/Relationship (T	ype, Print)		ng Address (Street					Code)
2	and and m 27 m 27 her tra		Alicia Lynch (Nied		-	Reservoi	r Rd., F	ulton, M			Sint
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en		20a. Method of Disposition  1 Burial 2 XCremation 3 D	Removal from State	emetery, crei	osition (Name of matory or other pla				ation - City or To	
Ħ	artmer ortant injury		4 □ Donation 5 □ Other (Specify,		2	itan Cren 2. Name and Addre	ess of Facility	17/00	Ale	xandria,	, VA
Ba	Depa Impo any i		Lanun 6	Litter	N	eptune S 821 E. S	ociety	ve., Spo	kane,	WA 992	02
12			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in dealh)	a	n	y u cad ia	info	netur			Onset and Death
7 9	/Medical Examiner		resulting in deality	Due to (or as a conseq	uence of):		V				
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Jue to (or as a sunsequ	uanes of):		-				
	cuted nd ransit	Examiner	that initiated events	C							
30,	The law requires that the death certificate be executed sie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	EX	resulting in death) Last	Due to (or as a consequent	uence of):						
68760,	cate t	edicai		d						1	
Box (	n certific anding p use as i	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		7-			23	3d. Dale of delive	эгу
_	death of attended for u	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown		JEctopic pregnanc ☐ Other (specify) _	у			Month	Day Year
P.0	that the de led by the a detached t	Phy	9 Unknown  Part II. Other significant conditions co		ulting in the u	n doshina daysa di	von in Part I	23e Did	tobacco us	e contribute to th	ne cause of death?
ds,	signed I	d by	atti. Ottor signinositi ooriations oo	THE SELECTION OF THE TOS.	aking in the d	indenying cause gr	voi iii aiti.	1	Yes 2		pably 4 🖾 Unknown
cor	w require s been sig should t	Completed						24a. Was	s an	24b. Were auto	ipsy findings available
Re	The far ete has page 2	omo						auto perf 1 ☐ Yes	ormed? 2 X No	death?	mpletion of cause of 2□ No
ital	: 3 E	BeC	25. Was case referred to medical examiner?					alh (Check only			
of V	Physician: r this certific ral director,	ပ	1 ☐ Yes 2 No		ER/Outpatier	IL SELDON		Home 5□Res			y)
nc	De Te	tion:	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	ryat ink? ]Yes 2. □No	28d. Describe	how injury	occurred	
Division of Vital Records,	after death. after death. I Director: Afte d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho	ome, farm, st		-			Number or Rura	al Route Number,
ā	tal or rs afte al Dir ed in	Cert	4   Homede	building, etc. (Specifi	y)			City of To	wn, State)		
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edicai		ysician: To the best of my kno niner: On the basis of examina and manner stated.							
	To the within ?	Med	29b. Signature and title of certifier	and marrier states.		29c. Licen	se number		29d. Date	signed (Month,	Day, Year)
			Kan	MD		Do	05370	9	8/	15/00	•
	15		30. Name and address of person who o		n 23a) (Type, UcM						MB 20715
in.		to.	31. Date filed (Month, Day, Year)	, , , , , , , , , , , , , , , , , ,			(Over 1/	EAL		Suzule	2011
3.0	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 9 20	32 Majistrar's Signa	R A						

			State of Maryland 1 - State Amend item#5, perFH, G858, 8/29/06 Ti	d / Depa	artment of Hertificate of L	ealth and M Death	lental Hygie	ene 2006	27241
	Physici /Medic		Decedent's Name (First, Middle, Last)     SHIRLEY	LEW]	IS .		2. Date of Death AUGUST	26, 2006	3. Time of Death 4:15 P M
	Examin		4a. Facility Name (If not institution, give street and number) HOSPICE OF BALTIMORE GILCHRIST		4b. City, Town, or	TOWSON			TIMORE
	Funeral Director		5. Social Security Number 1038 6. Sex 1 M 2 F 7. Age (In yrs. In 95		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	9. Birth	place (State or Foreign Intro) ENTINA
	Maryland show	ō	Usual Residence of Decedent	Town or Lo	Cation TIMORE				10d, Inside City Limits 1 ☑ Yes 2 ☐ No
	or 28a-	Director	10e. Street and Number	2.12	10f. Zip Code	0101		, Citizen of What Cou	
(0	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Items 23s or 28s-1 show aumatic event, the Madical Exams or must be exitlised at	Funerai	700 W. 40TH STREET  11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No		Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	, etc.
21215-0036	72 hours a natural', o	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	16a. Dece	1 Yes 2 X No	Specify:  tion  uring most of works	ing 16	Specify: b. Kind of Business/li	WHITE
2121	filed within Hygiene. other then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired)		1	ARD GOODS	
Maryland	should be fillind Mental H marked ott umatic ever	To Be	17. Father's Name (First, Middle, Last) NATHAN	СОНЕ		ANNA	e (First, Middle, Ma	uden Surname)	DORA
	12 th		19a. Informant's Name/Relationship (Type, Print) HERBERT LEWIS / SON					City or Town, State, Zi	
Baltimore,	permit. Pages 1 e Depertment of Hes Important: If Item eny Injury or othe once.		1 K Burial 2 Cremation 3 Bemovaldrom-State	emetery, crer	osition (Name of matory or other place HEBREW C	9)		REISTERST	
Balti	permit. Poppertmit importarienty injurients.		21. Signification of unexaltervice Uce/s	22	2. Name and Addres	s of Facility SO	L LEVINSO	N & BROS.	, INC.
	Fnysician		23a. Part f. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ent	er the mode of dying	g, such as cardiac o	or respiratory arres	t.	Approximate Interval Between Onset and Death
1	/Medical Examiner		disease or condition resulting in death)  a. Due to (or as a consequence)	ience of):	iterial is a	case of	Colon		·
8760,	ate be executed hysicien and the burial-transit	ai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence o	ence of):		0			J
P.O. Box 687	To the Hospitel or Attending Physicien: The law requires that the death certificate I within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the ettending physicomplately filled in by the funeral director, page 2 should be detached for use as the templately filled in by the funeral director, page 2 should be	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 roenths? 1	death 3[	Ectopic pregnancy Other (specify)			23d. Date of delia	very Day Year
rds, P	juires that n signed b uld be deta	d by Pi	Part II. Other significant conditions contributing to death but not resu		nderlying cause give	five	23e. Did toba 1 ☐ Yes	cco use contribute to	the cause of death?
Division of Vital Records,	The law rec ete hes bee page 2 shou	Complete	Lung Disease			<del>.</del>	24a. Was an autopsy performe	24b. Were aut prior to c death?	topsy findings available ompletion of cause of
f Vita	ysicien: is certific director,	To Be C	25. Was case referred to medical examiner?  1   Yes   2   No	ER/Outpatier	nt 3□ DOA Othe		(Check only one)	ce 6-TOther (Spec	Hospice
ion o	ending Ph eath. or: After th		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	at ? ∕es 2 ∐No	28d. Describe how	injury occurred	1
Divis	s efter de s efter de al Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	n 24 hour n 24 hour ne Funera	edical (	29a. Certifier (Check only one)  1 Certifying Physician. To the basis of my known one)  1 Medical Examiner: On the basis of examinat and manner stated.	vladga, daat ion and/or in	n occurred at the tim vestigation, in my op	e, data and piace, inion, death occurr	and due to the cau red at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	To the comp	×	29b. Signature and title of cartifier  Marthay Miles	cus	29c. License			Date signed (Month	
2	2		30. Name and address of person who come red cause of death frem	23a) (Type,	Print) N.C	hales.	S. Bo	lto md	212016
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signat	ture 1964					

		4	For State Registrar		State of	of Mary	land / [	Depai <i>Cert</i>	rtment of ificate of	Health and N <i>Death</i>	Mental Hy	giene 2 Reg. No.	006	27242
	ysicia Medic		Decedent's Name (First, Midd  JACI					L	ERNER.		2. Date of De.	_	200gr	3. Time of Death 3:04 P M
	amin	_	4a. Facility Name (If not institution 15	_	treet and nu ER COU				4b. City, Town,	or Location of Death BALTIMOR	E		unty of Death BALT	IMORE
Fun Dire	eral ctor		5. Social Security Number 219–16–4097	6. Sex	M 2□F	7. Age (In	yrs. last bir 82		If Under 1 Yea Months Day		8. Date of Bird (Month, Da 08/18/	y, Year) 1924	9. Birth Cou	nplace (State or Foreign untry) MD
faryland	ad at		Usual Residence of Decedent  10a. State 10b. County  MD BA	_TIM	ODE.	10	c. City, Tow		ation					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
with the ha	the notifi	Director	10e. Street and Number  15 TANNER COU		OKL			AL 11	10f. Zip Code	21208		10g. Citizer	of What Cou	untry? USA
·UUJO hours after death with the Maryland turel', or Iteme 23a or 28a-1 ehow	olical Examiner must be notified at	by Fur	11. Marital Status  1 Never Married 2 Mar  3 Nowled 4 Divorce	ried	2. Was Dec Armed F 1 X Yes If Yes, G Year or I	orces? 2 ☐ No live	in U.S.	lf '	as Decedent of Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No Rican, etc.)		Race - Amer Black, White ecify:	
2 2 0	the Medical	Completed	15. Decede (Specify only higher Elementary/Secondary (0-12)	nt's Educ est grade	completed,	(1-4or 5+) 2		Decede (Give ki life. Do	int's Usual Occ ind of work don O NOT use retii	upation e during most of work red) OWNER	king		of Business/I	NTRACTOR
Viand  Jiand  Ji	tic event,	To Be C	17. Father's Name (First, Middle ISADORE	Last)			LE	RNEF	₹	18. Mother's Nam GERTRU		Maiden Su		CZAINIK
and 2 short alth and h	er treume		19a. Informant's Name/Relation CHERYL A. LER			GHTER				et and Number or Rui INE COURT				
BAITIMOTE, MARYIANG 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than	ury or oth	91	20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 4 □ Donation 5 □ Other (	Specity)		State		ry, crema		PARK 8/27		RAI		TOWN, MD
permit Depart	eny in		21. Signature Furral Service					89	000 REIS	ress of Facility SO STERSTOWN	ROAD -	PIKES		
Pnysic /Med Exam	lical		23a. Part1. Enter the disease, c shock or heart failure. Lis Immediate Sause (Final disease or condition resulting in death)	r complit only on	e cause on	each line.		He		ving, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
cate be executed physician and	the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>\</b>			nsequence							
the death certification in the attending	ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2		birth 2 inant at time	Fetal death		Ectopic pregnar Other (s <i>pecify)</i>			230	i. Date of deli Month	very Day Year
	should be deta	Ď	Part II. Other significant condit	4		death but no	ot resulting is	n the und	derlying cause o	given in Part I.				the cause of death?
The la	page 2	Completed									24a. Was autop perfo	osy ormed?	prior to c death?	topsy findings available completion of cause of
OT VITA Physician: this certific	director,	o Be	25. Was case referred to medic examiner?		ospital:	71	2 ☐ ER/Ou		aC 200   C	26. Place of Dea other: 4 ☐ Nursing H			Jon	
n OT ng Phys fter this	_	-	27. Manner of Death 1 Natural 5 Pend	ina	28a. Date		28b.	Time of	28c. In		28d. Describe			:ny)
DIVISION O To the Hospital or Attending PI within 24 hours after death. To the Funeral Director: After the	d in by the fu	Certification:	2 ☐ Accident inves 3 ☐ Suicide 6 ☐ Could	igation	28e. Plac	ce of Injury - ding, etc. (S	At home, fa	ırm, stre	M 1 et, factory, offic	□Yes 2□No e	28f. Location ( City or To		lumber or Ru	ral Route Number,
n 24 hours	oletely filler	Medical C	29a. Certifier 1 Certify. (Check only one) 2 Medica	ing Phys I Examir	ner: On the	ne best of m basis of exa nner stated	amination an	e, death	occurred at the estigation, in my	time, date and place, opinion, death occur	, and due to the rred at the time,	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)
To the within	comi	2	29b. Signature and title of certific	er	1	_0	_			nse number こつにる		8/2	igned (Month	n, Day, Year)
21	1		30. Name a diddress of person	who co		use of death	A	(Type, P	Print)	Reistu	town,	~	924	3
Ro	Sta egistr		31. Date filed (Month, Day, Yea, AUG 2 9 2005	)		Registrar's	Signature	E.						

		ı	For State Registrar	State o	of Maryland /		artment rtificate			ınd M	ental Hy	giene Reg. No.	2001	5 27243
	Physicia /Medic		1. Decedent's Name (First, Middle, Margaret		ary						2. Date of De August	26	20ඊේ	3. Time of Death 1:40 Р м
	Examin		4a. Facility Name (If not institution, Stella Maris				Ti	moni					County of De Baltim	ore
	Funeral Director		216-48-3599	6. Sex 1 □ M 2 🛣 F	7. Age (In yrs. last b	Yrs.	If Under Months	1 Year Days	II Under 2 Hours	Min.	April	$\overset{\text{th}}{1}\overset{\text{y}}{1}\overset{\text{gar}}{,}$	1910 <sup>9. B</sup>	inthplace (State or Foreign Country) Maryland
	within 72 hours after death with the Maryland ene. then 'neturel', or iteme 23s or 28s-f ehow ha Medical Examinat must be indiffied at	ector	Usual Residence of Decedent  10a. State	ord	10c. City, To Be	own or Lo		Code				10g, Cit	zen of What (	10d. Inside City Limits 1  Yes 2 No
	s 23s or	Funeral Director	1512 Regent		1-15	100	2	21014		i=2 (Caa	ait. Van an N			USA nerican Indian,
9600	ours after de irel', or Items Examinar u	by	11. Marital Status  1 □ Never Married 2 □ Marrie  3 ☒ Widowed 4 □ Divorced	Armed F	2 ሺ No ive		was Deced f Yes, spec		Specify:	nn? (Spe , Puerto I	cify Yes or No Rican, etc.)	)-	Black, Wh	
Maryland 21215-0036	be filed within 72 hours after death with the Marylan ital Hyglene. Id other then "neturel", or Items 23a or 28a-f show or event, the Medical Examination at the notified at	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	grade completed	(1-4or 5+)	(Give life.	dent's Usua kind of wor DO NOT us kkeep	k done d e retired)	tion uring most	of worki	ng		nd of Busines	e Roads
land	S should be filed withir and Mental Hygiene. Ie marked other then aumatic event, the H	To Be C	17. Father's Name (First, Middle, L James H. Burch	ast)						r's Name	(First, Middle gle	, Maiden	Sumame)	
Mary	s 1 and 2 should F Health and Men Item 27 Ie marke other traumatic	2 13	19a. Informant's Name/Relationsh Dr. Margaret Le								<i>Route Numb</i> d. Aust			
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If Item 27 It eny injury or other tra		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (Sp	ecify)	State ceme	tery, crei	esition (Name matory or of edral	ther place		B <b>-29</b> -	-06		cation - City o	
Balt	Depart Depart Import eny in		21. Signature of Fundal Savice	ensee	-	22	RUS6	Tows York	on Facility	Tew	on, Mome	i: 25	204	
	Physician /Medical Examiner		23a. Part1. Enter the disease, of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequential y list conditions,	a. Due to	Or di Or Or as a consequence	Y (	or the mode	the ol dying	, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
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rds, P.	quires that n signed t uld be deta		Part II. Other significant condition	contributing to	death but not resulting	g in the u	nderlying ca	ause give	n in Part I.		23e. Did			to the cause of death?  Probably 4 Unknown
Il Records,	The law requir cete has been si page 2 should	Completed by				,			<del>-</del>		24a. Was auto perf 1 - Yes		prior to death?	
Vita	Physician: The this certificete ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2 ☐ ER/	Outnatie	nt 3□ DO	Othe			n <i>Check only</i> me 5 ☐ Res		6 □Other /Sr	nec(f)
Division of Vital	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: After this certificacompletely filled in by the funeral director.		27. Manner of Death  ↑☆Natural 5 ☐ Pending 2 ☐ Accident investig	28a. Date (Mo		D. Time o		8c. Injury Work		:	28d. Describe			
Divis	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 289. Plac	e of Injury - At home, ding, etc. (Specify)	larm, st	reet, factory	, office			28l. Location ( City or To			Rural Route Number,
	the Hosp nin 24 hou the Fune npletely fil	Medical	(Check only 2 Medical E	xaminar: On the	ne best of my knowled basis of examination nner stated.		vestigation	, in my op	inion, deal			date and	place, and d	ue to the cause(s)
	To with	2	29b. Signature and title of certifier  30. Name and address of person of	V Q V	use ol death (Itam 23)	M(	DD	) S	2 7	40	)	AUC	US (Mo	28 M 2006
	5		ERNESTINE WRI	GHT, M.D	. 2300 DL	JLANI		LLEY	ROAD	TI	MONIUM,	, MD	21093	
	Sta Registi		31. Date filed (Month, Day, Year)  AUG 2 9		Registrar's Signature		arti							

DHMH 17 Rev 1/2001

AUGUST 26, 2006

MARGARET LEARY

State of Maryland / Department of Health and Mental Hygien 2006

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** August 25, P M 2006 6:40 Lane Gavle K. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Manor Road 12631 Glen Arm If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax **Funeral** Months Days 1 ☐ M 2 🛛 F 215-92-530 37 January 30,1969 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, its Modical Exacting main be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Glen Arm 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 12631 Manor Road 21057 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Own\_Home Homemaker 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Miller L. Ε.\_ ۵ Garv Grace Breidenbaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:1
Department of Health ar importent: if item 27 ie any injury or other trau Mark D. Lane Husband 12631 Manor Road Glen Arm, Maryland 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State
☐ Donation 5 ☐ Other (Specify)
21. S) nature of Fineral Service Iconsee 8-30-2006 Wilson UMC Cemetery Long Green Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 1050 York Road Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Metastatic Immediate Cause (Final Breast **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto for as a consequence off Examiner be executed use as the burial-transit Due to (or as a consequence of): physicien Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No Year Day 4☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Š signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 🗌 Yes 2 No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Be examiner Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Pl 24 hours after death. Funerel Director: Atter to Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place ol Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital ( within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 126/06 UNCOLOGIST D0056919 Sonegan 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) 5 6701 N. Charles Street Towson, Maryland 21204 Robert Donegan, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 2 9 2006 Registrar

			For State	tate of Maryland / Department of Health and M	2006 27216	**
	\$		Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No. 2006 27245 2. Date of Death 3. Time of Death	)
	Physici /Medic		EMMIE	MOORE	AVGUST 27 2006 4:45 AM	
1	Examin	er	4a. Facility Name (If not institution, give stre GOOD SAMARI	et and number)  7AN HOSPITAL BALTIMOR	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex		8. Date of Birth (Month, Day, Year)  2 - 19 - 11  9. Birthplace (State or Foreign Country)  SQ 44 (QOLAN	20
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits	_
	e Man 8a-f sh	ctor	MD	Baltinare	1 Ares 2 No	
	with th	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
	r death	ınera	11. Marital Status 12.	Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Speramed Forces?)  If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.	
036	be tiled within 72 hours atter death with the Maryland nat Hyglene.  do other than "natural", or items 23s or 28s-f show event, the Medical Examinar must be multiled at	by	Contract of the second	1 □ Yes 2 □ Specify: Year or Dates:	Specify: Black	
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212	od within glene. er than "	Сотр	Elementary/Secondary (0-12)	Gollege (1-40r5+) Teacher	Baltimore(ity	P
and	uld be tiled Mental Hygi irked other itic event, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maiden Surname)	
Maryland	2 should and Men Is marks aumatic	O_	19a. Informant's Name/Relationship (Type,	P(int) daughter 19b. Mailing Address (Street and Number or Rural	Route Number, City or Town, State, Zip Code)	_
-	1 and Health em 27 ther tr		Beulah Hora 20a, Method of Disposition	Je 8 6405 aurelton  20b. Place of Disposition (Name of Dis	AUC, Balto, MD 21212 ate 20c, Location - City of Town, State	7
E S	000		Usurial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	comptent or material attendant	/1/00 Baltingon, MT	
Baltimore	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service Licensee	\$2 Name and Aidress of Facility  Value of the Control of the Contr	ense Funeral Serva	_ ろ
£.)	10240		23a. Part1. Enter the disease, or complicati	ons that caused the death. Do not enter the mode of dying such as cardiac or	respiratory arrest, Approximate	-
	Physician		shock, or heart failure. List only one of Immediate Cause (Final disease or condition		Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):		
21	<b>₽</b> ∉	ner	Sequenfially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):		
h3.	be execute icien and burial-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):		_
8760,	cate be executed physicien and the burial-transit	dical	d			_
9	leath certific attending p	/Мес	IF FEMALE: 23c. 23c.	ff yes, outcome of pregnancy	23d. Date of delivery	
D. Box	The law requires that the death certificate sie has been signed by the atlending phys page 2 should be detached for use as the	Completed by Physician/Me	in the past 12 months?	1	Month Day Year	
P.	that the de ned by the a detached t	y Phy		uting to death buf nof resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?	
ords	equires sen sigr ould be	ted b	ATRIAL	FIBRILLATION.	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown	
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ital		Be Co	25. Was case referred to medical examiner?	26. Place of Death	1 ☐ Yes 2 No 1 ☐ Yes 2 No (Check only one)	-
of V	Physician: r this certition ral director,	P	1 □ Yes 2 No	17 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Hom	te 5 ☐ Residence 6 ☐ Other (Specify)  8d. Describe how injury occurred	_
ion	ath. r: After	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	.8a. Date of Injury (Month, Day Year)  28b. Time of 28c. Injury at Work?  Injury  M 1 ☐ Yes 2 ☐ No	ad. Describe now injury occurred	
Division of Vital Records, P.O.	of attending after death. I Director: After din by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)	
_	To the Hospital or Attending Physician: within 24 hours atter death.  To the Fundral Director After this certific completely Illied in by the funeral director,		(Check only 2 Medical Examiner:	an: To the best of my knowledge, death occurred at the time, date and place, and On the basis of examination and/or investigation, in my opinion, death occurre	nd due to the cause(s) and manner as stated.	_
	outher vithin 24	Medical	one) 29b. Signature and title of certifier	and manner stated.  29c. License number	29d. Date signed (Month. Dev. Year)	-
			Marisho	Ball, MD D00589	13 AUGUST 27 2006	2
	8		30. Name and address of person who comp	eled cause of death (flem 23a) (Type, Print) 5 601 LC BOULEVARD; BA	13 AUGUST 27 2006 OCH RAVEN 21239 LTIMORE MARYLAND	
3	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	CHINOKE WINNY CHIVE	-
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				ORIGINAL		

	f'		For State Registrar	State of Maryland	/ Departme	ent of Health ate of Deal	n and Mer th	ntal Hygiene Reg. No	2006	27246
	Physici	an	1. Decedent's Name (First, Middle, Last)		144 -	٠		Date of Death Month Da		3. Time of Death
100	/Medic	ai	505/e 4a. Facility Name (If not institution, give s.	treet and number)		ttiSon	18.29	igust 26	2000 County of Death	18:23 M
	Examin	er	The Johns Hopkir	11. 1	Ba	Itimore	11 1	4	NIA	
	Funeral Director		Social Security Number 6. Sex	7. (ge (In yrs. las	t birthday) If Und Month		s Min.	Date of Birth (Month, Day, Year)	Cou	place (State or Foreign ntry)
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, 1	Town or Location					10d. Inside City Limits
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	th with the 23a or 28	al Direc	100. Street and Number 1703 E. Lafaye Ho	Λ.,		Zip Code 2 2 1 2 1 :	3	10g. Cit	izen of What Cou	ntry?
036	within 72 hours after death with the Maryland ene. than 'natural', or items 23e or 28e-f show the Macinal Exemiter may be multied at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	If Yes, s	cedent of Hispanic pecify Cuban, Mexi 2 No Spec	ican, Puerto Rici	Yes or No- an, etc.)	14. Race - Ameri Black, White Specify:	
15-0	"natur	leted	15. Decedent's Educ (Specify only highest grade		16a. Decedent's U (Give kind of life. DO NO	work done durina n	nost of working	16b. K	ind of Business/Ir	,
21215-0036	d withir giene.	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)  5+ Years		astor			Keligii	on
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: if item 27 is marked other than any injury or other traumatic avant, Illia Mange.	To Be (	17. Father's Name (First, Middle, Last)  Frank Jones			18. Ma		irst, Middle, Maiden da Me		e
Aary	2 should and Men is marks rsumatic	_	19a. Informant's Name/Relationship (Typ		19b. Mailing Addre			oute Number, City o		
	s 1 and f Health itsm 27 other ti	. 68	20a. Method of Disposition	20b. Plac	ee of Disposition (finitely), crematory of	lame of	Date	ay Apt.	ocation - City or T	
Baltimore,	Pages Iment of tant: if it jury or o		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		ng Memi	Vial Park			indsor N	1111, MD
Bal	permit. Page Department Important: if sny injury or 20028.		21. Signature of Funeral Service License	1 Mo136	3 Varial	and Address of Fa Ln C. Give 5 York R	ene Fur	ieral Sen imore M	D 21212	
			23a. Part1 Enter the disease, or comblic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.			,			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequen	ranjaj nce of):	Hemor	nag	e		1 Day
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8	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b>	terio-v	enous v	nA/for	mation	L	inknown
<b>€8</b> 160, <b>€</b>	rcate be executed physicien and s the burial-transit	dicai Ex	resulting in death) Last	Due to (or as a consequer	nce of):					
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	The law requires that the ate has been signed by the bage 2 should be detache	ρ	Part II. Other significant conditions conf	ributing to death but not resulti	ng in the underlyin	g cause given in Pa	art I.	23e. Did tobacco u		the cause of death?
ecor	law require as been si 2 should l	Completed						24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
a B	Physician: The lav this certificate has al director, page 2 a							performed?	death?	
₹	Physician: r this certifica ral director, p	To Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2 🗆 EF	VOutpatient 3□	Other	ace of Death (C	heck only one) 5 ☐ Residence	6 □Other (Speci	(v)
Division of Vital Records,	ing Phi After thi funeral	ion: T	27. Manner of Death 1 Natural 5 ☐ Pending	- Angle	Bb. Time of Injury	28c. Injury at Work?	28d	Describe how injur		<i>,,</i> ,
visio	To the Hospital or Attending Ph within 24 hours after death. To the Funers! Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	M e, farm, street, fact	1 ☐ Yes 2 ory, office		Location (Street ar City or Town, State	nd Number or Rur	al Route Number,
٥	pital or ours afte ersi Dir filled in			ician: To the best of my knowle	adae death coour	nd at the time, date	and class and			*****
	To the Hospital within 24 hours a To the Funeral completely filled	edicai	(Check only 2 Medical Exemin	er: On the basis of examination and manner stated.	n and/or investigati	on, in my opinion,	death occurred a	it the time, date and	d place, and due t	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	MAD		9c. License numb	er A	29d. Da	te signed (Month,	1 0 1
	1.		30. Name and address of person who cou	poleted cause of death (Item 2)	3a) (Type Print)	KE2-C	000	Mug	UST 2	0 2006
	6		30. Name and address of person who cor	vi MD GOON	. Wolfe	St. 134	Ltimoi	re mo	21287	7
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 2 9 2	32. Registrar's Signatur	di Gos	de la company de				

State of Maryland / Department of Health and Mental Hygier 2006Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1250 AM SARAH MORRIS 24 2006 AUGUST /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE JOHNS HOPKINS BAYVIEW CARE CENTER BALTIMORE CITY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
OCTUBE: 21, 1924 Mississippe 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🔀 🖡 358-16-8238 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. other than "natural", or Itams 23a or 28a-f show ant, tre Modical Examiner must be notified at 1 Yes 2 No Baltimore **Funeral Director** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 5505 Bayview Circle 21224 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after I □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Be Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Private Duty Nurse 7 is marked othat traumatic evant, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill timent of Health and Mental Hitant: If itam 27 is marked off jury or othar traumatic evan Mary Nancy Foster Chester A. George ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lynnette H. Kauffin Daughter 6409 Grafton Garth Ct. Glen Burnie MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry August 24, 2006 Hanover Department o Important: If any injury or once. 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy 6 Hs Registry 21. Signature of Funeral Service Licensee 7522 Connelley Drive Suite P. Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA OF ALZHEIMER'S TYPE Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical 25 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ pe 1 Yes 2 No 3 Probably 4 Wunknown HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No Division of Vital to the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Varursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending 1 Yes 2 🗌 No death. investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide hours after within 24 hours a To tha Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Mi D0063164 2006 AUGUST 24 dharan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVE SEI DHARAN BALTIMORE, MD 21224 ANIZUDH 31. Date filed (Month Day 2 Year) 2006 32 Registrar's Signature Registrar

			For State Registrar	State of	Maryland		artment of hartificate of			gien <b>2e () (</b> Reg. No.	16	21248	
	14		Decedent's Name (First, Middle,	Last)					2. Date of De.	ath		3. Time of Death	_
- '	Physicia		Nathan				Marsha	11	August	Day 16, 20	Year 06	2:35 P M	
	/Medic Examin		4a. Facility Name (If not institution,	give street and num	ber)			r Location of Death		4c. County			_
- ;		. 28	4012 A. Night	Heron Cou	ırt		Waldorf			Char	1es		
	Funeral			5. Sex 7	. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da			place (State or Foreign	)
Ħ	Director		066-14-3972	1 <b>∑</b> M 2□F	86	Yrs.	Months Days	Hours Mill.	June 1	7,1920		NY	
	pu ,=		Usual Residence of Decedent		10a Cib	/. Town or Lo	ention					10d. Inside City Limits	
	aryla ehov	<u>_</u>	10a. State 10b. County				Callon					1⊠Yes 2 □ No	
	Ba-f	Director	MD Charle	S	Wa.	ldorf	101 7: 0-1-			40a Cisinaa at i	What Car		_
	vith ti	F	10e. Street and Number				10f. Zip Code			10g. Citizen of	what Cou	intry r	
	e 23	era i	4012A Night Her	on Ct.	test Ever in III	C 13 1	20603	Hispanic Origin? (Sp	acty Vas or No	USA 14 Bac	re - Amer	can Indian,	
38	should be filed within 72 hours after death with the Maryland to Mental Hygiene. marked other than "neturel", or iteme 23a or 28a-f ehow matic event, the Medical Examinat mast be notilied at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Marrie  3 ☐ Widowed 4 ☐ Divorced	Armed Ford	ces?		f Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Bla	ck, White y: Whi	, etc.	
21215-0036	72 hou	eted	15. Decedent's (Specify only highest	Education		(Give	dent's Usual Occup kind of work done	during most of work	king	16b. Kind of B	usiness/lr	ndustry	_
121	within iene. rthan	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	US 1	DO NOT use retire Navy	d)		US Gove	rnme	nt/Militar	У
	Hyg other	BeC	17. Father's Name (First, Middle, L	ast)		L.		18. Mother's Nam	e (First, Middle,	Maiden Sumar	ne)		_
Maryland	Mental Mental arked o	To B	Julius Marshal	1				Mae Co	oy1e				
a <sub>Z</sub>	2 should and Men is marks eumatic		19a. Informant's Name/Relationship	p (Type, Print)		19b. Mailir	ng Address (Street	and Number or Rui	ral Route Numbe	er, City or Town	, State, Zi	p Code)	_
	s 1 and 2 should if Health and Mer Item 27 is marks other treumatic		Kimberly D. Mar	shall/Dau	ghter	10600	N. Keys	Road, Br	randywir	ne, MD	2061	3	
e,	of He of He fitem r oth		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Location	- City or T	own, State	
Ĕ	Pages nent of int: if it iry or o		1 ☐ Burial 2 【XCremation 4 ☐ Donation 5 ☐ Other (Sp.		Met Cre	ropol: emator	natory or other pla itan V	08/1	7/2006	Alexand	lria,	VA	
Baltimore,	permit. Pages Department of Important: If It any Injury or o		21. Signature of Funeral Service L	icensee	me	100		ess of Facility No.			l Par	k, FL 3333	4
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that ca	used the death						2	Approximate Interval Between	
3	Physician		Immediate Cause (Final disease or condition	A P	les	2-	-lia	Lus	lere	lun		Onset and Death	
	/Medical		resulting in death)	aDue to (d	a consequ	perice of):	-	1/					
	Examiner		Convention lies and divine	, de	the	201	ela	reter					
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	Due to (c	as a consequ	uence of):							Т
•	ocuted nd transi	Examin	cause. Enter Undertying Cause (Disease or injury that initiated events	c. /	me	20	Kuo	n			l,		
ဂ္ကိ	cate be executed physician and ; the burial-transit		resulting in death) Last	Due 56 (s	as a consequ	uence of):							
8760	cate t	dical		d									
× 6		Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc						23d. Da	ite of deliv	verv	
. Box	it the death certiti by the attending tached for use as	Iclar	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregna	rth 2 ☐ Fetal ant at time of de		]Ectopic pregnanc ] Other (s <i>pecify</i> ) _	у			onth	Day Year	
0	t the by the	hys	9 🗆 Unknown	9□ Unkno	wn				_				_
	res tha igned l	by P	Part II. Other significant condition	s contributing to de	ath but not resu	ulting in the u	nderlying cause	en in Part I.	23e. Did t	obacco use con	tribute to	the cause of death?	
ğ	w require been si should b	ed	Comment.	10000	1	con	0	acry-	1 0	Yes 2□No	3 Pro	bably 4 Unknown	1
Records,	e law n has be je 2 sh	Completed	arly	kzme	n,	14	me	- col	24a. Was	an 24b.	Were aut	opsy findings available ompletion of cause of	)
	yslcien: The is certiticate ha	E O	necon	met.	K					rmed?	death?		
Vita	slcien: Th certiticate rector, pag	Be	25. Was case referred to medi all examiner?					26. Place of Dea	th (Check only o	one)			
	hysic his ce I dire	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ In	patient 2	ER/Outpatier	t 3□ DOA Ot	her: 4 Nursing H	ome 5 Resi	dence 6 □Ott	ner (Spec	ify)	
	ding Phy h. After thi funeral o	<u></u>	27. Manner of Death  1 ∠Natural 5 □ Pending	28a. Date o (Month	f Injury n, Day Year)	28b. Time o Injury	Wo		28d. Describe	how injury occur	rred		
S	tendi leath. tor: A	cati	2 Accident investigation in Accident investigation in Accident investigation in Accident investigation in Accident investigation in Accident investigation in Accident investigation in Accident investigation in Accident investigation in Accident investigation in Accident investigation in Accident investigation in Accident investigation in Accident investigation in Accident investigation in Accident investigation in Accident investigation in Accident investigation in Accident investigation in Accident in Accident investigation in Accident investigation in Accident i	ation	<u> </u>			]Yes 2 □No					_
Division of	after d after d I Direct d in by	Certification;	4 Homicide determin	and 286. Place	of Injury - At ho ig, etc. (Specify	ome, farm, sti /)	eet, factory, office		City or To		ber or Hui	al Route Number,	
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certifica completely tilled in by the funeral director, to	Medical C	29a. Certifier (Check only one)	Physician: To the xaminer: On the ba	sis of examinal	wledge, deat tion and/or in	h occurred at the t vestigation, in my	me, date and place opinion, death occur	, and due to the rred at the time,	cause(s) and m date and place,	anner as	stated. to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier		an I	,	29c. Licen	se number	159	29d. Date signe	d (Month	, Day, Year)	
			fre	ce 11			1/6	100 /	1	ung.	11	2000	_
	5		30. Name and address of person w	no completed cause	of death (Item	23a) (Type,	Print)	31 6	500	MID	20	730	
1 第	Sta Registi		31. Date filed (Month, Bay, Yaar)		istrar's Signa	ture	Angle)						
15	A 440		AUU Z U	CUUU	Market A	1							_

06-06158 Dawnyel Mary Moore

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 27249

-		1- For State Registrar	Certific	ate of D	eath	Re	eg. No.	) 4147
Physicia Medical Exami	an/	Decedent's Name (First, Middle, Last)  Dawnye	1 Moore			2. Date of Dea Month August 18	Day Year	3. Time of Death 0507 hrs
		4a. Facility Name (if not institution, give stree Harbor Hospital	et and number)		City, Town, or Location of altimore		4c. County of Death	1
Funeral		Social Security Number 6. Sex	7. Age (In yrs. last bir	thday) If	Under 1 Year If Under	r 24Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Bir	
Director		19 90 11	2 F	O Yrs.	onths Days Hours	Min. June 2	2, 2004 Foreign	untry) Maryland
' any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location	DU.			10d. Inside City Limits
daryland <b>28a-f show any</b> 1 at once.	tor	Maryland NJH  10e. Street and Number			Saltimore f. Zip Code	, <u> </u>	On Citizen of What Cour	1 Yes 2 No
ith the Maryland 23a or 28a-f sho	Director	2950 Caner Ro	l.		2/22	5	0g. Citizen of What Cou	SA-
ath with items 23	uneral		Was Decedent Ever in U.S Armed Forces?		ecedent of Hispanic Orig specify Cuban, Mexican		- 14. Race - Ameri White, etc.	ican Indian, Black,
after de al", or iner mu	by Fu	3 Widowed 4 Divorced If Yes or Da	Yes 2 Mo Give Year tes:	1 Yes	S 2 No specify		Specify: 6/	ack
2 hours afte "natural", Examiner	ਰ	15. Decedent's Education (Specify only high			Isual Occupation (Give I of working life. DO NOT		16b. Kind of Business/l	ndustry
5-0036 iled within 72 Hygiene I other than '	Complete	0			NA		NA	-
Fed Hyg	Be Cc	17. Fathers Name (First, Middle, Last)				s Name (First, Middle, Manager)		
MD 2121 d 2 should be fi th and Mental n 27 is marked umatic event,	ပ	19a. Informant's Name/Relationship (Type, P		b. Mailing Ad	dress (Street and Num		ber, City or Town, State	Zip Code)
ore, MEss 1 and 2 soft Health at If item 27		20a. Method of Disposition	20b. Place	of Disposition tory or other p	(Name of cemetery,	Date	20c. Location - City or	Town, State
Page nent ant:		4 Donation 5 Other Specify:	anova nom otato	ine fo	rk Cemeter	18/26/06	Woodlawn	Maryland
Baltime permit. Page Department Important:		21. Signature of Funeral Service Licensee	iku	22. Name	and Address of Facility	For Fuy	wal Home	P. 1 229
Physician /Medical		23a Part I. Enter the disease, or complication failure. List only one cause on each line		ot enter the m	ode of dying, such as ca	ardiac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
Examiner			adden unexplained (or as a consequence of):	death ii	n infancy (SUI	OI)		Death
	ь	Sequentially list conditions, if any, leading to immediate Due to	(or as a consequence of):					
-1	Examine	Cause. Enter Underlying Cause (Disease or injury that initiated	(or as a consequence of)		-,- <u>-</u>			1
ecuted 1 and 1 transit		d	(or as a consequence or)					
lal al	n/Medical	*	item#23a,27		oerME,g860, 10	)/6/06 TT	Tool Ball (1)	
		23b. Was decedent pregnant in the past 12 months?	Live birth	2 Fetal d	eath 3 Ectopic	pregnancy	23d Date of delivery  Month	V Day Year
P.O. Box 68 s that the death cert gned by the attending detached for use a	Physicia	1 Yes 2 No 9 Unknown 9	Unknown	5 Other	(Specify)		Î	
P.O.	þ	Part II. Other significant conditions contr	buting to death but not resultin	ng in the unde	rlying cause given in Pa		bacco use contribute to	
ords, P.C w requires that as been signed be	leted			· · · · ·		24a Was autop	an 24b. Were au	atopsy findings available completion of cause of
Reco The law cate has	Completed			1,78		perfor	med? death?	
Division of Vital Records, rat or Attending Physician: The law requinrs after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should t	Be	25. Was case referred to medical examiner?	al: 1 Inpatient 2 V ER/C	outnationt 3	26.Place of Death		Residence 6 Other	
n of Vil ding Physid After this funeral dir	n: To			Time of Injury			now injury occurred	
Sion Attendi r death. ector:	catio	Z Accident	nd 8/18/2006 Fn 8e. Place of Injury - At home, f			unknwon	Name to and Name to as D	THE ALL MAN AND A COL
Divisior Hospital or Attend 24 hours after death Funeral Director:	Certification:	Suicide Suicide Could not be	Specify) Residence		etory, office building, ea		Street and Number or Ru tate) 2950 Carve e, MD	r Road
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use	Medical (	one) 2 Medical Examiner: On the	o the best of my knowledge, de ne basis of examination and/or					
To To cor	Med	29b Signature and tripe of certifier	nanner stated	* * *	29c. License number		29d. Date signed (Mor	nth, Day, Year)
		30. Name and address of person who complete	stad/cauloo of floath /liom 22=1		O.C.M.E.		August 18, 2006	
				11 Penn S	treet, Baltimore, M	/ID 21201		
Si Regis	tate trar	31. Date filed (Month, Day, Year)  AUG 2 9 2006	32. Rogatrar's Signature	hand				
DHMH 17 Rev 1/2	_	7.50 11 2 2010	OF	RIGINAL				

State of Maryland / Department of Health and Mental Hygiene 2006 27250 For State Ragistra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 25 2006 James T. Menikheim August 9:00pt /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Baltimore Middle River 1507 Shore Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Aug. 19, 1935 MAryland Hours 1√2 M 2 □ F 213-34-7999 71 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location in then "natural", or iteme 23s or 28e-f ehow the Medical Examiner must be notified at Baltimore Middle River MD 1 ☐ Yes 2 X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21220 1507 Shore Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ģ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) e filed within at Hygiene. BGE Elementary/Secondary (0-12) College (1-4or 5+) Lineman 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 end 2 should be fil iment of Heelth and Mental H tant: If item 27 is marked otl Betrice Butta Joseph Menikheim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara H. Menikheim /wife 1507 Shore Road Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rossville MD 8/28/06 permit. Page Department of important: if eny injury or once. Gardens of Faith 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave.Balto. MD Connelly Funeral 21221 Home of Essex nn 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, -Dé Immediate Cause (Final disease or condition resulting in death) Physician 0 o Muni /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ettending physicien and I for use as the burial-transit equires thet the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month 4☐ Pregnant at time of death signed by the elid be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed?

1 Yes 22 No certificete or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No this ieral Director; After th 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending efter death. 1 Yes 2 No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours eff To the Funeral Di completely filled in 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 056 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROAD 9512 HARFORD BALTO. MARYLAND ANAMA 31. Date filed (Month, Day, Year) 32. Agistrar's Signature State AUG 2 9 2006 Registrar

			For State of Maryle Registrar		artment of H <i>tificate of I</i>			ien <b>&amp; () () 6</b>	27251
	Dhuaiai		Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Day Year	3. Time of Death
	Physici /Medic		William Herbert Maurer				August		5:35 p M
	Examin	er	la. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death		4c. County of Dea	
			Greater Baltimore Medical Co	enter yrs. last birthday)	Towson If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Baltimor	e hplace (State or Foreign
	Funeral Director		218-46-0730	59 Yrs.	Months Days	Hours Min.	Nov. 2,	1946 Mar	y I and
_	and		Jsual Residence of Decedent  10a. State 10b. County 10c.	. City, Town or Lo	cation				10d. Inside City Limits
	Maryi -feho	Ď	Maryland Baltimore Co.	Fullerto	on				1 ☐ Yes 2 No
	r 28a	rec	10e. Street and Number		10f. Zip Code		11	0g. Citizen of What Co	puntry?
$\supset$	th with	aiD	4000 Marjeff Place Apt. C	;		21236		United S	States
2	after death with the Marylan or iteme 23e or 28e-f ehow	ner	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13. V	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
Villion 15-0036	within 72 hours after death with the Maryland ene. Then "naturel", or Iteme 23e or 28s-f ehow fre Moorcel Examiner must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ሺ Married 1 ሺ Yes 2 ☐ No If Yes, Give Year or Dates: Vie	tnam	Yes XX No	Specify:		Specify: W	hite
	72 hou nature	ted	15. Decedent's Education	16a. Deced	lent's Usual Occup	ation		16b. Kind of Business	/Industry
\(\frac{1}{2}\)	thin 7	nple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life. L		during most of working	ng	Baltimore	*
2	e filed wi it Hygien other th	Cou	12 yrs.		Fireman	10 14-45 - 4- 14	(5) haiddle h	Fire Depar	rtment
E Bud	d at a	To Be	17. Father's Name <i>(First, Middle, Last)</i> Herbert Maurer			18. Mother's Name Marie	Willi		
Warvi	2 should and Men ie marke	۰	19a. Informant's Name/Relationship (Type, Print)					City or Town, State,	
Ž.≥	1 and 2 Heelth a		Mrs. Jacqueline M. Maurer/Wife					altimore,	
	ges 1 ar t of Hee if item or othe				sition (Name of natory or other plac	1		20c. Location - City or	
Baltim	it. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Specify)  21. Signeture of Fungial Service Licensee Michael E. C		rest VA Cen	netery 08/3		Owings Mill 805 Harford	s, Maryland
Ba	permit. Pages 1 Department of I Important: If ite eny injury or ot		21. Signature of Furnacing Service Security Principles E. C	0.00		. Ruck, Ir		iltimore, M	
			23a. Part1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.		-	_	r respiratory arre	est,	Approximate Interval Between
	Physician	8 Y	Immediate Cause (Final disease or condition resulting in death)  a. Acut R  Due to (or as a con Sequentially list conditions.	enal F	ailure				Onset and Death  month
	/Medical Examiner		resulting in death)  Due to (or as a con	isequence of):	C : 1	A			19622
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	genic sequence of):	(Irrh	10515			year
3	ansit ansit	Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events						
0	en an	Exa	resulting in death) Last Due to (or as a con	sequence of):					
68760.	eath certificate be executed attending physicien and for use as the burial-transit	edical	d						
	ding p		IF FEMALE: 23c. If yes, outcome of pre	agnancy		· · · · · · · · · · · · · · · · · · ·		22d Date of de	i
Вох	atten for us	Physician/M	in the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)	′		23d. Date of de Month	Day Year
0.0	t the d by the tached	hysi	1 ☐ Yes 2 ☐ No 4 ☐ Freghant at time 9 ☐ Unknown 9 ☐ Unknown						
o,	res that the de igned by the a be detached f	by P	Part II. Dther significant conditions contributing to death but not	resulting in the ur	nderlying cause give	en in Part I.		pacco use contribute to	
of Vital Records.	v requir been s should	Completed					-		obably 4 Dunknown
Jec Jec	ne law has t	ш					24a. Was a autops perform	n 24b. Were at prior to death?	utopsy findings available completion of cause of
<u></u>	ician: The Certificate harector, page		25. Was case referred to medical		<del></del>	an Disease Disease	1 ☐ Yes 2	2 No 1 ☐ Yes	2□ No
5	ysician: is certific director,	To Be	examiner? Hospital:	2 ER/Outpatien	t 3 DOA Oth	er: 4 Nursing Hor		e) ence 6 ☐Other (Spe	city)
0	ig Phy ter thi		27. Manner of Death 28a. Date of Injury	28b. Time of				ow injury occurred	Unity/
(10)	utending Ph death. ctor: After th y the funerel	atio	2 Accident investigation	,, injury		Yes 2 □No			
Lo sivid	or Atterdent de Directe in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Ptace of Injury - / building, etc. (Sp	At home, farm, streetify)	eet, factory, office	-	28f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certiful 24 hours either death.  To the Funcati Director: After this certificate has been signed by the attending completely filled in by the funerel director, page 2 should be detached for use a		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, death	occurred at the tin	ne, date and place, a	and due to the ca	ause(s) and manner a	s stated.
	To the He within 24 To the Fu	Medical	(Check only one)  2 Medical Examiner: On the basis of examiner and manner stated.	miation and/or in					
	Vit To Con	2	29b. Signature and title of certifier		29c. Licens			9d. Date signed (Mont	
	. ^		1 onan y some	(Hom 22c) (Time	Print)	43489		ong co	2006
	1.2		30. Name and address of person who completed cause of death  Brian J. Bohner 6535 A		enny	Par North	56 6	50 Ral.	2 2006 4 MD Z1Z04
	Sta Regist		Brian J. Bohner 6535 A 31. Date filed (Month, Day, Year) 32. Registrar's S	ignature	1 . 10 .			- / ·	

State of Maryland / Department of Health and Mental Hygien2006

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year :50P M **Physician** AUGUST 20 200% CAROLINE D. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE DUNDAIK HERITAGE NUISINS If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours MA 1□M 2□F 96 Yrs. 215-01-6087 Sept 19, 1909 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-1 show the Medical Examiner must be notified at 1 Yes 2 No Rosedale BALITIMORE Funeral Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ U.S.A Neper Ave 21237 1414 238 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? or Items 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 ☐ Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 7 is marked other than traumatic event. It s Mis BOARD School NIA 7th Cook 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Mental Hy Important: If Item 27 Is marked other any injury or other traumatic event 000. 17. Father's Name (First, Middle, Last) Be Hen55 HelenA Hebbel Frederick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NoTTinsham MO 21236 DAWN-L. Griffin Shoreham CT. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/24/06 Rosedale, MD. GARdens of FAITL 22 Name and Address of Facility
PAUL STELLA FUNERAL Home, PA
7527 harford RD. BALTO. MD 2 21. Signature of Funeral Service Licensee Stella aul M. RO. BALTO MA 21234 23a. Pah1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ete has been signed by the attending physicien and page 2 showld be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 🗌 Yes 2 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \[ \text{Yes} \] 2 \[ \text{No} \] 24a. Was an autopsy performed? res 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of The th Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manne Death 28d. Describe how injury occurred 28b. Time of After 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide filled in by 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who sompleted (se of death (kep) 23 Type, Photo 10 - A R BALTIMOR 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 27253 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician Barbara Bernhard MacLea August 2006 10:30a.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 29 Murray Hill Circle Baltimore Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March 6, 1934 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New Jersey **Funeral** Months 137-28-1806 1 □ M 2 🛱 F 72 Yrs. Director Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 Murray Hill Circle 21212 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or then any injury or other traumatic event, the Mudical Evantrical ODE. ☐Yes 2X No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 27 No Specify: Completed by If Yes, Give Year or Dates: Specify. White 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Affairs Director American Cancer Society 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Bernhard Elizabeth Failing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Virginia Murtaugh (Daughter) 75 Hennelskamp Road Wilton, Conn. 06897 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ' 4 ☐Donation 5 ☐ Other (Specify) Baltimore, Maryland Green Mount Crematory 8-28-06 21. Signatore of Funeral Service Liquid 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) toronchuctasis **Physician** /Medical **Examiner** 64struct 1201 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Records. P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy page 2 should be detached for in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) the the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Ses 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 2 No Division of Vital 1 Yes To the Hospital or Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only Hospital: 1 ☐ Inpatient 10 1 Tyes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) this 27. Manne of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year) Aug. 28, 2000 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towson 701 Charles N. 31. Date filed (Month, Day, Year) . Registrar's Signature State AUG 2 9 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #8 Per State 85 Masy 124 66 egg rtment of Health and Mental Hygiene 2006 27254 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** ELIZABETH MAGDALINE McCAFFREY MUSGROVE August 26, 2006 6:30 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GENESIS ELDERCARE: BRIGHTWOOD Lutherville Baltimore County If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth 1920 **Funeral** Months Days 1 ☐ M 21 F 85 Director 215-42-7329 Oct 1, 1929 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 X No Director Maryland Baltimore County Timonium 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 12300 Rosslare Ridge Road, #101 USA by Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Sales Clerk Retail Dept Store 10 vrs 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be find Mental 1 and Mental John Thomas McCaffrey Teresa Magdalina Hoffman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 Ia rr any injury or other traum once. Richard E. Musgrove, Sr. (Husband) 12300 Rosslare Ridge Rd, #101 Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/29/2006 Lutherville, Maryland Saters Bpt. Ch. Cem of Fundal Service Dicentee Martin D. Lawson

Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road, Baltimore, Maryland 21212

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Course (Fig. 1) Approximate Interval Between Onset and Death Immediate Cause (Final ONGESTIVE **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy ormed? 2 X No 1 ☐ Yes or Attanding Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 1 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 1 Natural 2 Accident Division 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deat To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier TC crifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08 Name and address of person who completed cause of death (Item 23a) (Type, Print) Chaules Street Scelto MD 21209 Twikner MD/6565 N.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 9 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 2005

27255 1 - State Registres Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 23, 2006 ear **Physician** 16:43 MEADOWS JAMES. JR /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Laurel Regional Hospital Laure1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 15,1955 Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** Months Days Hours Min. 1**M**M 2□F Maryland 51 Yrs 214-72-0979 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or Items 23s or 28s-f show traumatic event, the Musical Examinant natal be notified at 1 Yes 2 No Linthicum Maryland Anne Arundel Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21090 U.S.A. 6862 Baltimore-Annapolis Blvd. 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status be filed within 72 hours after di tal Hygiene. d other than "natural", or Item Black, White, etc 1 Never Married 2 Marned White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Self-Employed Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any lighty or other traumatic event page. Carnes James E. Meadows Levina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21090 19a. Informant's Name/Relationship (Type, Print) 6862 Baltimore-Annapolis Blvd.Linthicum, Maryland Donna D. Meadows (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 08-29-06 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Funeral Service Licen Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction Immediate Accute /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease 12 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death signed by the at id be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown Hypertention been si 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No Hyperlipidemia s certificate has b lirector, page 2 s 2 No Old Myocardial Infarction 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ဥ this 28a. Date of Injury (Month, Day Year) After thi funeral of 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 | Homicide within 24 hours a
To the Funerel C 😥 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the reuse(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner-stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0023811 \*-25-06 rman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1406 B South Crain Hwy #304, Glen Burnie, Maryland 21061 Jonathan Forman 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 9 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20061 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 8:25 Franklin William Novak 2006 Sr. August 22 /Medical Facility Name (If not institution) give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner NECLEA CHAP 7. Age (In yrs. last birthday) Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 6,1928 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Days Hours 77 212-26-7103 Oct. Director MD Usual Residence of Decedent filed within 72 hours after deeth with the Maryland Hygiene. Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "naturel", or Items 23s or 28s-1 show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Harmans 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? 7510 Harmans Road 21077 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Tes 2 No White Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) **Glazer** Glass and Mental Hygie permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy, important: If Item 27 is marked othe ery Injury or other traumatic event, pages. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Andrew Novak Blanch Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Grace Novak /Wife 7510 Harmans Road Harmans, Maryland 21077 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Aug. 29, 20c. Location - City or Town, State 1X Burial Z□Cremation 3 □Removal from State 4 □ Donayion 5 □ Other (Specify) New Cathedral Cem. 2006 Baltimore, MD. 21. Signature of Fune at Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. Second Avenue SW Glen Burnie, Maryland 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** itoni er /Medical Due to (or as a consequence of): Examiner abdominal Perforated Esquentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien and for use as the burial-translt Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? á CINOMO 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2√ No ٩ 1 Anpafient 2 ER/Outpatient 3 DOA ieral Director: After thi 28c. Injury af Work? 27. Manner of Death 28a. Dafe of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 3 Suicide 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimone Medical toin 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State

OFIGINAL

Registrar

AUG 2 9 2006

Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

				1 - For Amend #23d per	tate of N	Maryland / 18729 /	Depai Cert	tment of H	ealth and I Death	Mental Hy	giene 0	06	27257
		Physici	an	Decedent's Name (First, Middle, Last)	lenry	William	Novo	tny		2. Date of De Month	eath Day	Year	3. Time of Death
		/Medic Examin		4a. Facility Name (If not institution, give stre			T	4b. City, Town, or	Location of Death		4c. Coun	006 y of Death	
				Harford Memorial H  5. Social Security Number 6. Sex		l 1 Age (In yrs. last bir	thday)	Havre d	e Grace	8 Date of Bi		arfor	d place (State or Foreign
		Funeral Director		214-03-1813 <sup>1</sup> 2 M	2 F			Months Days	Hours Min.	(Month, Di Feb.	16,1920	Cou	ryland
	-	ahow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loca	ation				1	10d. Inside City Limits
		Sad at	ector	Maryland Harford				T	A.	berdeen			1 ☐ Yes 2, ☐ No
00		deeth with the Maryland ema 23a or 28a-f ahow er must be politied at	I Dir	10e. Street and Number 901 Barnett Lane	Apt. 3	18		10f. Zip Code	1001		10g. Citizen of United		
12			unera	The state of the s	Armed Force	nt Ever in U.S. s?	13. W	as Decedent of Hi Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)	0- 14. Ra Bla	ce - Ameri ick, White,	can Indian, , etc.
	036	within 72 hours after ene. than "natural", or Ite ne Madical Exemin	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	MYYes 2[ If Yes, Give Year or Date:		1 [	☐Yes 2☐xNo	Specify:		Spec	fy:	White
X	15-0	n 72 ho "natui	leted	15. Decedent's Educati (Specify only highest grade of	on ompleted)	16a.	. Decede (Give ki	int's Usual Occupa ind of work done d O NOT use retired,	tion uring most of wor	rking	16b. Kind of I		ydock &
	N	THE R. LEWIS CO., LANSING, MICH.	Comp	11 Years	College (1-4d	or 5+)		der			Shipbu	ildin	_
0	land	a d a b	Be	17. Father's Name (First, Middle, Last) William Novotny					18. Mother's Nan Margar	ne <i>(First, Middle</i> et Holz		me)	
7	ary	d 2 should the and Ment of 1s marked traumatics	2	19a. Informant's Name/Relationship (Type,			_	Address (Street a					
7	e, N	1 and Heeli		Mrs. Jeanette Hash  20a. Method of Disposition	Daugni			Leight Ro tion (Name of atory or other place		ngdon, M	faryland		
19	altimor			1 Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from Sta	10		atory or other place. . of Jesu		3/22/200	6 Dur	dalk,	, Maryland
8	Balt	permit. Page Depertment of Important: If any injury or once.		21. Signatur of uneral Service Licensee	2/	11	22.	Name and Addres	s of Facility Funeral	Home of	Dunda1	ķ, Įņ	1522
0				23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caus	sed the death. Do	not enter	922 Wise the mode of dying	73 Y C 1	undalk, or respiratory		Id 2.	Approximate Interval Between
		Physician /Medical		Immediate Cau Final disease or condition resulting in death)		+SPIRAT	101	•				AILUEE	Onset and Death
		Examiner			,	as a consequence SWALLO		G PRO	ble M	•: 			Sdays
>		pel le lisc	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury		as a consequence	of):		00E				e al ou a
nin	ó	ate be executed hysicien and the burial-transit		that initiated events cresulting in death) Last		MENT AT	of):			1.			saye
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11/10	.O. Box	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funaral Diractor: After this certificate has been signed by the attending pl completely filled in by the funeral director, page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth	me of pregnancy 2 Petal death t at time of death		Ectopic pregnancy Other (specify)	N/A.			ate of deliv	Day Year
PVOTA	S, P	es that gned by be deta		Part II. Other significant conditions contrib			n the und	derlying cause give	n in Part I.	23e. Did			the cause of death?
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之	Rec	The law ite hes	Completed by	DEHYDRATI CHRONIC K	IDDE	Y DISE	1-21			24a. Was auto perf 1 \( \text{Yes}		prior to co death?	opsy findings available ompletion of cause of
	Vital	ician: certifice ector, p	Be	25. Was case referred to medical examiner?	nital-		bc +-5115	1000	26. Place of Dea	ath (Check only	one)		
	ot	g Physier this seral dir	n: To	27. Manner of Death	1 Mnpa 28a. Date of In (Month, i	njury 28b.	tpatient Time of Injury	3□ DOA Cthe 28c. Injury Work	4 Li Nursing r	lome 5 Res	how injury occu		(y)
	Division of Vital Records,	ttandin death. :tor: Afi	catlo	2 Accident investigation 3 Suicide 6 Could not be		-		M 1 🗆 Y	r Yes 2□No	29f Location	/Street and Nue	bar ar Dur	al Route Number,
	Div	s after al Dirac	Certification:	4 Homicide determined	building,	Injury - At home, fa etc. (Specify)	arm, stree	et, ractory, office			wn, State)	ber or Hur	ar House Number,
		ha Hospi in 24 hour ha Funar pletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physici 2 Medical Exeminer	en: To the be On the basis and manner	s of examination an	e, death ond/or inve	occurred at the time estigation, in my op	e, date and place inion, death occu	e, and due to the irred at the time	cause(s) and n date and place	anner as s , and due t	stated. o the cause(s)
		To t To t	Σ	29b. Signature and title of certifier	C	0		29c. License	number 60532	_	29d. Date sign	1	Day, Year)
	,	161		30. Name and address of person who comp		of death (Item 23a)	(Туре, Р				03/1	11-0	
	6	Sta	ite.	ANURAA6. SOC	32 Aegi	19 W/	ALN	IUT CA	NE, F	FBERD	EEM.	M.	Δ.
	8	Registi		AUG 2 9 2006	Jan .	strar's Signature	A ch	West					

			For State Registrar	State of Mai	ryland / Dep <i>Ce</i>	partment of H e <i>rtificate of l</i>	ealth and N Death	Лental Нуд в	giene 2006	27258
			1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea Month	th Day Year	3. Time of Death
	Physici /Medic		Lillie Haze	l O'Shea				AUGUS		
	Examin		4a. Facility Name (If not institution, give Saint Joseph		Center	4b. City, Town, or	Location of Death		4c. County of Dea	timore
	Funeral Director		5. Social Security Number 6. S 253-14-7727	ex 7. Age ☐ M 2 【X F	(In yrs. last birthday 83 Yrs.	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Oct. 9.	, Year)	rthplace (State or Foreign country) abama
	D .		Usuel Residence of Decedent  10a, State 10b, County		10c. City, Town or I	conting				10d. Inside City Limits
	shov	j.			Toc. City, Town or t		орра			1 ☐ Yes 2 X No
	28a-f	Director	Maryland Harf	U/La		10f. Zip Code	, p p ec		l 0g. Citizen of What C	country?
	th with 23a or	ai Di	67 Neptune Driv	e			21085		u.s.A	·
036	be filed within 72 hours after death with the Marylend lat Hygiene. d other then "natural", or items 23a or 28a-f show event. I're Medical Examinar must be notified at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	ver in U.S. 13	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		
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2	within ene.	npie	Elementary/Secondary (0-12)	College (1-4or 5+	.)	re kind of work done of DO NOT use retired	)	9	Own H	ame
	filed w Hygier other ti	Co	17. Father's Name (First, Middle, Last)		Hom	iemaker	18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	ome
Maryland		To Be	Leon Homer No				Lillian		Pettes	
37	should be and Mental marked o umatic eve	ř	19a. Informant's Name/Relationship (		19b. Mai	iling Address (Street			r, City or Town, State,	Zip Code)
	s 1 and 2 should if Health and Mer itsm 27 is marks other traumatic		Ms. Debbie Skilln	nan (niece	) 67	Neptune D	rive, Jox	opa, MD	21085	
altimore,	of He of He If itsm		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Removal from State		ematory`or other plac	e)	Date	20c. Location - City o	
Ē	t. Pag tment tent: tjury o		4 ☐ Donation 5 ☐ Other (Specify	v)		Crematory	1			, Maryland
Ba	permit. Pages. Department of I Importent: If its eny injury or of one.		21. Signature in 9 neural ervice later	<b>1</b> 596					Funeral Ho e, MD 2123	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	he death. Do not e	nter the mode of dyin	g, such as cardiac	or respiratory are	rest,	Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition	a. STROKE						Onset and Death
ı	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
Ì	*	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to for as a	consequence of					
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Ω.	ned by	by Ph	Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	w requires been sign should be		DEMENTIA					1 □ Y	es 2 No 3 ☐ F	Probably 4 Unknown
Il Records,		Completed						24a. Was a autop perfor 1 Yes	sy prior to	
Vita Vita	ticien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	00	th (Check only o		
o	Phys r this ral dir	To	1 ☐ Yes 2 No 27. Manner of Seath	Hospital: 1 Inpatien 28a. Date of Injury			4   Hursing H	**	ence 6 Other (Sp ow injury occurred	ecify)
O O	Attending Physicien: If death.  •ctor: After this certific by the funeral director.	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	Wor	k? Yes 2 □ No		J	
Division of Vital	after dea Director	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injurbuilding, etc.	ry - At home, larm, : (Specify)	street, lactory, office		28l. Location (S City or Tow	itreet and Number or F n, State)	Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)  1 Certifying Pt 2 Medical Exar	ysicien: To the best of niner: On the basis of and manner stat	examination and/or	ath occurred at the tin investigation, in my o	ne, date and place pinion, death occur	, and due to the d rred at the time, d	ause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To th within To th comp	Me	29b. Signature and title of Certifier	1	MO	29c. Licens			29d. Date signed (Mpi	nth, Day, Year)
•	Ĩ		20 Name and address of access upo	Completed as 1	01 (V)		2096		0/0)/	
	M		30. Name and address of person who				rue mouc	SUN MAD	/ YLAND 21	2014
78	Sta		31. Date filed (MAN Gay Year) 20	32. Registra	r's Signature		VE I UWS	AFILITATION	TEMMU CL	C-V/4
ř	Regist	ar	10 0 20	16 Sill Ever	St. fr	coles				

		ı	For State Registrar	State of Maryland	•	t of Health and e of Death	Mental Hygier	2006	27259
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	il Pitt J	TR		2. Date of Death Month 0	Day Year 4 2006	3. Time of Death
	Examin		4a. Facility Name (If not institution, give s	reet and number)	tal 4b. City	Town, or Location of Dear		4c. County of Death	
I	Funeral Director		5. Social Security Number 6. Sex 251-23-89 42	M 2 F	t birthday) If Under Months	1 Year If Under 24 Hrs Days Hours Min		9. Birthpl Count Ma	
	aryland •how	ır	Usual Residence of Decedent  10a. State 10b. County	10c. City, T	Fown or Location				0d. Inside City Limits 1 X es 2 □ No
	ith the Mi or 28a-f	Funeral Director	10e. Street and Number	B	10f. Zip	Code	10g. (	Citizen of What Coun	
	ems 23e	neral	2252 ( C ) A	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Dece	dent of Hispanic Origin? (S city Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, e	
5-0036	i 72 hours after death with the Maryland "netural", or itema 23e or 28e-f ehow idical Examinat must be notified at	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes			Specify: Bla	ich
21215-(	E 100	Completed	15. Decedent's Educ (Specify only highest grade Elementhry/Secondary (0-12)		16a. Decedent's Usua (Give kind of wo life. DO NOT u	rk done during most of wo	rking 16b.	Kind of Business/Ind	lustry
nd 21	d 2 should be filed within th and Mental Hygiene. 7 Ie marked other then traumatic event, the Me	Be Col	17. Fatheris Name (First, Middle, Last)		ruck	18. Mother's Na	me (First, Middle, Maid	ansoon	Marian
laryla	2 should and Men le marke aumatic	Ç	19a. Informant's Name/Relationship	i++ 5R	19b. Mailing Address	Street and Number or R	_		
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Baltimor	it. Pagi rtment rtent: h njury o		Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	MT	Zion Cen	neter 81	9/06 B		ervices
Ä	Derm Depa Impo eny l		23a. Party Enter the disease, or complic	ations that caused the death.	Do not enter the mod	E you Rolle of dying, such as cardia	c or respiratory arrest,	ND UZI	2
}	Physician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Hepatoren		chome			Interval Between Onset and Death 7 days
	Examiner	j.	Sequentially list conditions, if any, leading to immediate	A Scites O	and Sp	intaneous	bacterial	Peritonitis	2 months
\$.	be executed icien and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Circhosi's  Due to (or as a consequen	of line	r			2 yrs
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Ω.	ires that the signed by the following the detactions of the detactions of the following the followin	by	Part II. Other significant conditions con	ributing to death but not resulting	ng in the underlying o	ause given in Part I.		o use contribute to the	
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ital B		Be Con	25. Was case referred to medical examiner?			26. Place of De	performed 1 ☐ Yes 2 ☑ 1 ath   Check only one	? death? No 1 ☐ Yes	ŽŽ No
of V	Phys r this ral dii	2	1 ☐ Yes 2 ☐ No H		VOutpatient 3 DO	Other: 4 Nursing I	dome 5 Residence		9
Division of Vital Records,	ten deat tor: the	ertification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home	М	1 Yes 2 No		and Number or Rural	l Route Number,
ā	To the Hospital or Al within 24 hours eftar of To the Funeral Direc completely filled in by	O	29a. Certifier 1 Certifying Phys	building, etc. (Specify)  ician: To the best of my knowle	edge, death occurred	at the time, date and place	City or Town, Sta	(s) and manner as sta	ated.
	To the Hospital within 24 hours of To the Funeral I completely filled	Medical	(Check only 2) Medical Examin	ar: On the basis of examination	n and/or investigation	in my opinion, death occ	irred at the time, date a	and place, and due to	the cause(s)
	4		Kamal Ban	goria M.D	). A	T243894	6-83	08/14/	2006
	8		30. Name and address of person who co	e leted cause of death (Item 23	3a) (Type, Print) Inion Mer	norial Hosi	201 Dital Ba	E. UNIVER	ND-21218
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 9 2	and manner stated.  GORIA M. D. D. L. L. D. L. L. L. L. L. L. L. L. L. L. L. L. L.	to face	r		, ,	

06-06388 Gloria Payne

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		- For State Certificate of D		Reg N	2001	0 2126
Physici	an/	1. Decedent's Name (First, Middle,Last)		Date of Death Month Da	v Year	3. Time of Death 0915 hrs
ledical Exami		Gloria Jean Payne 4a. Facility Name (if not institution, give street and number)  4b.	City, Town, or Location of Death	August 26, 20	4c. County of Death	09151115
I			Randallstown		Baltimore Cour	nty
Funeral				8. Date of Birth(M	IM/DD/YYYY) 9. Birth Foreign	place (State or
Director		$228-78-1237$ $_{1\square M}$ $_{2\square F}$ 54 $_{Yrs.}$	Months Days Hours Min.	01/29/5	2 Cou	ntry) VA
Ý	Ī	Usual Residence of Decedent  10a. State				10d. Inside City Limits
i tow any e.		MD Baltimore Windsor	Mill			1 Yes 2 XNo
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number 1	Of. Zip Code	10g. (	Citizen of What Count	ry?
th the Maryland 23a or 28a-f sho notified at once.	ä	3391 Lord Baltimore Drive	21244		USA	
h with ems 23 t be no	Funeral		ecedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto R		14. Race - Americ White, etc.	an Indian, Black,
er deat	됩	1 Yes 2 X No	es 2 X No specify:		Afric	can-
urs aftu tural" amine	g p	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's	Usual Occupation (Give kind of wo		Specify: Amer b. Kind of Business/In	1can dustry
6 72 ho un "na cal Ex	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	of working life. DO NOT use retire		Baltimor	
003 within giene ner tha	шо	5+ School  17. Father's Name (First, Middle, Last)	Teacher		oublic Sc	nools
215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica	0		Annie L		•	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Menrall Hygien and Parland and Tris marked other than "natural", or items 23a or 28a-f She matic event, the Medical Examiner must be notified at once	70 E		ddress (Street and Number or Ru	rai Route Number	, fity or Town, State,	
<b>-</b> p = e €		Kia Ericka Payne/Daughter 3391 20a. Method of Disposition 20b. Place of Disposition	Lord Baltimor	e Dr.	Windsor <sup>2</sup>	Mf44, MD
Baltimore, cermit Pages I ar Department of Hee Important: If ite		1 X Burial 2   Cremation 3   Removal from State	F/		oodlawn,	
Baltimo permit Page Department of Important: injury or ott		4 Donation 5 Other Specify: King Mem. 21. Surabule of Frontal Service Licenses 22. Nan	ne and Address of Facility WV 1	16 F/II	T.A. of	Balto. Co
Balt permit Depart Impor injury		1/2/1/1/1/1/20	O liberty Rd	Randa	llstown	MD 21133
Physician	1	236. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause in each line.	mode of dying, such as cardiac or	respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	7	Immediate Cause (Final dise se or condition resulting in death)  Due to (or as a consequence of):	ism			Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b. Deep Venous Thromboses				
	iner	if any, leading to immediate cause. Enter Underlying Cause			,	
_	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
ecuted and trans		d				
760, icate be executed g physician and the burial - transi	Medical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy			23d Date of delivery	
		23b. Was decedent pregnant in the past 12 months?	death 3 Ectopic pregnan		Month D	ay Year
Box 687 e death certifi the attending ed for use as t	Physician		(Specify)			
b.O. Bothat the de red by the detached f	P	Part II. Other significant conditions contributing to death but not resulting in the unc	erlying cause given in Part I.	23e. Did tobac	cco use contribute to t	ne cause of death?
res that signed loe det	d by			1 Yes 2	2 No 3 Prob	ably 4 🗸 Unknown
ords, w requir	Completed			24a Was an autopsy	prior to co	opsy findings available ompletion of cause of
Reco The la icate ha	Į W			performed 1 Yes 2		s 2 No
Vital Regarding The his certificate director, page	Be	25. Was case referred to medical examiner? Hospital: 4 Inpatient 2 FR/Outpatient	26.Place of Death (Check o			
n of Vital Records, ding Physician: The law require.  After this certificate has been s funeral director, page 2 should d	유	1 Ves 2 No Impater 2 Erooupation 22. Manner of Death 28a. Date of Injury 28b. Time of Injury		Home 5 Res 28d. Describe how	sidence 6 Other:	
Sion C stending death. ctor: Af	Certification:	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 No			
Division tal or Attendi rs after death. "al Director: /	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street,	factory, office building, etc.	28f. Location (Stre		al Route Number, City
Divis  Spital or A  hours after  meral Dire  y filled in b	Sed	4 Homicide determined (Specify)  29a Certifier 4 Castifician Physicians To the best of psylonoglogic death occurrent				
Division of Vital Records, P.O. Box 68  To the Hospital or Attending Physician: The law requires that the death certificate the hours after death.  To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation				
Te with To	Med	and manner stated  29b. Signature and title of certifier	29c. License number	29	9d Date signed (Mon	th, Day, Year)
		Carol Halla	O.C.M.E.	_ A	August 27, 2006	
		30. Name and address of person who completed cause of death (Item 23a)	root Politimers BID 04004	'		
\	tate		reet, Baltimore, MD 21201			
Regi		31. Date filed (Mont) Och Year) 9 2006 32. Redistrar's Signature				

		1	For State Registrar	State	of Marylan		artment of I			/lental		ene 0	06	27261
DATE			1. Decedent's Name (First, Middle,	Last)							of Death			3. Time of Death
Phys			Lawrence W. 1	hilpott						Augu		Day 25	Year 2006	11:45a M
Exam	dica nine	_	4a. Facility Name (If not institution,		umber)		4b. City, Town,	or Location	of Death	-	J. C.		y of Death	
			Heritage Harbo	ır			Annapo	lie				Ann	e Arı	inda1
Funer	al		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Unde	r 24 Hrs.	8. Date	of Birth		9. Birth	place (State or Foreign
Direct			563-18-5703	1 <b>₹</b> 1M 2□F	9	1 Yrs.	Months Days	Hours	Min.	May	th, Day,	1915		intry) Souri
p.		- 1-	Usual Residence of Decedent		140.00									
aryle phoy		. !	10a. State 10b. County	_		y, Town or Lo								10d. Inside City Limits 1   Yes 2   No
8a-f		Director	Maryland Prince	George	Ну	attsvi								
ith th	1	2	10e. Street and Number				10f. Zip Code				10	g. Citizen of	What Cou	untry?
ath w	1		7005 Barton					784				USA		
eb re		Funeral	11. Marital Status	Armed i	cedent Ever in U. Forces?	S. 13.	Nas Decedent of I f Yes, specify Cub	Hispanic O pan, Mexica	rigin? (Sp in, Puerto	ecify Yes Rican, et	or No-		ice - Amer ack, White	ican Indian, , etc.
36 safte		D I	1 Never Married Marrie	If Yes, C	2. 2. No Sive		I∐Yes 2X No	Specify	<i>r</i> :			Speci	ity: Wi	nite
21215-0036 ad within 72 hours af giene. or then "naturel; or the Modical Expire.		ם D	3 Widowed 4 Divorced	Year or	Dates:	100 D-00	tanta Harri Oan					05 Kind of 6	2	
15 n 72 n 72 n 72 n 72 n 72 n 72 n 72 n 7		Completed	15. Decedent' (Specify only highest		1)	(Give	tent's Usual Occu kind of work done DO NOT use retire	during mo	st of work	cin <b>g</b>	'	6b. Kind of E	ousiness/ii	ndustry
with energy		E C	Elementary/Secondary (0-12)	College	(1-4or 5+)		1f Emplo	,			(	Constr	uctio	on
THE PERSON	9		17. Father's Name (First, Middle, L	ast)				18. Moth	er's Nam	e (First, A	liddle, M	aiden Suma	me)	
nore, Maryland 21215-0036 spes 1 and 2 should be filed within 72 hours after death with the Maryland at of Heath and Mental Hygiene. It flem 27 is marked other than "natural", or items 23a or 28a-f abow or other treumatic event, the Mulical Expiriter must be cutilised at	1	o Re	John D. Philpe	ott				Et	he1	Silve	<b>≥y</b>			
shou mar	1	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	g Address (Stree				•	City or Town	n, State, Zi	ip Code)
Md 2 lith a 27 is	1		Gwen Marshman/I	auchter		913	2 Fortune	e P1.	Edge	ewate	r. M	D 210	37	
s 1 a f Hez item	1	1	20a. Method of Disposition			lace of Dispo	sition (Name of natory or other pla	1		Date	-	0c. Location		own, State
mo Page ento ento y or			■ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp				oln Ceme		8/29	/2006	5 B1	rentwo	od, l	Œ
Baltimore, permit. Pages 1 ar Department of Hea Important: if item:	- SOUCE		21. Signature of Funeral Service L			Ě	Name and Addr	ess of Faci	uner	g1 Hg	me .	hood	MD	20722
4034	ч		quin	1//	me	3							TID	
H S-D			23 Part1. Enter the disease, or of shock, or heart failure. List of	on y one cause or	each line.	n. Do not ent	er the mode of dy	ing, such a	s cardiac	or respira	tory arres	st,		Approximate Interval Between Onset and Death
Physicia	_		Immediate Cause (Final disease or condition resulting in death)	a	the	MU	DI NO							2 weeks
/Medic Examin	_		resulting in dealin)	Due t	o (or as a consequ	uence of):			1	- A				0 1 . 1
N. 16		_	Sequentially list conditions,	b. — Dun t	Con	4024	iver	lear	+	For	WM	0		of meety
- pg #		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	o (or as a consequ	uence or):	h 0	h	eu	200	ath			many years
and and I-tran		Xan	that initiated events resulting in death) Last	c	o (or as a consequ	IADCA OF	Copar			-	-	r		
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X 6 Sertific ding p		/Me	IF FEMALE:	23c If ves c	utcome of pregna	ncv						004 B	-44 -15	
Bo Bath c		lan	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fetal	death 3	Ectopic pregnand Other (specify)	cy .					ate of deliv Ionth	∕ery Day Year
I Records, P.O. Box 6  The law requires that the death certifi ste has been signed by the attending a  age 2 should be detached for use as		by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unk		94(II 3 L	Other (specify) _				_			
that the ded by detail	Ġ	5	Part II. Other significant condition	ns contributing to	death but not resu	ulting in the u	nderlying cause gr	ven in Part	1.	23e.	Did toba	acco use cor	ntribute to	the cause of death?
Division of Vital Records, if or Attending Physician: The law requires the read that this certificate has been signed in by the funeral director, page 2 should be earlied.	1										1 🗌 Yes	2 □ No	3 🗀 Pro	bably 4XUnknown
v requ		ete					~-			040	146	0.41	18/	
De lay		Completed								244	Was an autopsy perform	ed? 240.	prior to co	opsy findings available ompletion of cause of
all n: It ficate fr, pa										10	Yes 2	No	1 🗌 Yes	2 No
VIt sicial certi	0	מ	25. Was case referred to medical examiner?	Hospital:			- Ot			th (Check				
Phy rathis		<u> </u>	1 Yes 2 No  27. Manner of Death	1		ER/Outpatier 28b. Time of	I 3LI DOA	41,200	lursing Ho			nce 6 □Ot		ify)
ding Afte fune		100	1 Natural 5 Pending 2 Accident investig		e of Injury onth, Day Year)	Injury	Wo	ork? ]Yes 2.[	1No					
Atten deal ctory y the	1	Ica	3 ☐ Suicide 6 ☐ Could n	ot be	ce of Injury - At ho	me, farm, str				28f. Loca	tion (Stre	et and Num	ber or Rui	ral Route Number,
O Selection of the sele		Certification:	4  Homicide determine	buil	lding, etc. (Specif)	()	,,				or Town,			
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: Affer this certificate ha completely filled in by the funeral director, page			29a. Certifier 1 Certifying	Physician: To t	he best of my kno	wiedge, deati	occurred at the t	me, date a	nd place.	and due	to the car	use(s) and m	nanner as	stated.
• Ho 24 h • Fur	1	edical	(Check only 2 Medical E	ent no trenimax	basis of examination	tion and/or in	estigation, in my	opinion, de	ath occur	red at the	time, dat	te and place	, and due	to the cause(s)
To th Within To th			29b. Signature and title of certifier	$\cap$			1 .	se number	4 =		29	_		, Day, Year)
	5		1 ( Don.)				D	405	19			8.	28	06,
0	A	-	30. Name and address of person v	vho completed ca	use of death (Item	1 23a) (Type,	Print)							
7			Mirza Nussaree,					ofton	, MD	211	14			
W-1	State		31. Date filed (Month, Day, Year)	32	Abrietrar's Sinna	turo								
Reg	stra	r	AUG 2 9	2006	Colors A	5. A	whi							

State of Maryland / Department of Health and Mental Hygiene 27262 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 27 2008 ar 4:56 A M **Physician** PELC LAURIE HELENE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE OWINGS MILLS 20 BIRCH BARK COURT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 05/09/1956 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 💢 F 50 NY 218-66-1986 Yrs. Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: if item 27 is marked other then "neturet", or items 23a or 28s-f show eny injury or other treumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State BALTIMORE OWINGS MILLS 1 ☐ Yes 2 No Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 BIRCH BARK COURT 21117 USA 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify δ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4055+) **BOOKKEEPER** LIOUOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NEIER ADRIAN ٧. ROSANSKY LEIGH ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 BIRCH BARK COURT - OWINGS MILLS, MD 21117 JONATHAN PELC / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State BETH TFILOH CEMETERY | 08/28/2006 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Emeral Service Lic 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or rear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic **Physician** break gers /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence off or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 25No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2. X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 Other: 4 Nursing Home Medical Certification: To 1 Inpatient 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No within 24 hours after death To the Funeral Director: , completely filled in by the f 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D28239 Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, mp 51 1650 Orleans Davidson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 2 9 2006

State of Maryland / Department of Health and Mental Hygiene 2006 27263 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Geraldine M. Pyles August 2006 1015 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL 6. Sex HARBOR SALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Monfhs Days Hours 1 □ M 2]( F 69 219 32 7514 27, 1937 Director Jan. Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow Director N/A 1 TYes 2 □ No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 3900 South Hanover Street Apt. #1 U.S. Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, efc. Peges 1 and 2 should be filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: À Specify: White 3 XWidowed 4 Divorced "netural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I're Mu Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Loretta Wagner Phillip Kurth 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 s Department of Health ar Important: If Item 27 Ia any injury or other trau Sherry Dorsey / daughter 7114 Balto. & Annapolis Blvd. Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland Cedar Hill Cemetery 8/28/2006 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. nomeon 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death CARDIAC DYFRHYTHMIA **Physician** moned iste /Medical Due to (or as a consequence of). Examiner CORONARY ANTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed MY PERTENSION Due to (or as a consequence of): Box 68760. Din Betes Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the detached Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did fobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4. Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2- No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 No 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury af Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending after death.

Director: Aff
in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, faith occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and meaner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and odresa of person who completed cause of death (ttem 23a) (Type, Print) D3001 J. HANOVER ST. BALTIMORE MO. BUKOVITZ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 29 Registrar

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State of Maryland /	Department of Health	and Mental Hy	giene 2 (	0	6

For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 14 2006 3. Time of Death Day 11 Month ten 11.25. p. M **Physician** UTH ROUSE Aug /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Peath Examiner Kandallstown orthwes 05 ener TIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 212-18 1 M 2 9 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Completed by Funeral Director Maryland 10e. Street and Number 10g. Citizen of What Country? 1602 238 12. Was Oecedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. or Reme 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubag, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced "neturel", 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

WYSE 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othin eny liqury or other treumatic event ADEs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be 19a. Informant's ame/Relationship (Type, Print) 19h. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Hullo Mar 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral service Licensee 23a: Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 0 Adenocarunoma **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical signed by the attending phys I be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Oate of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? dueode 1 485 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 Yes 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA within 24 hours after deeth.
To the Funerel Director: After th
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Oate signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 长 August 2006 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) whiten Hamegwern 1 Kangaraga 31. Date filed (Month, Day, Year) 32 Segistrar's Signature State 2006 Registrar

Physicia		State Registrar		•							Date of Deat Month		2006	3. Time of De	ath
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Funeral Director		5. Social Security I 218-68-7	240	3. Sex 1 □ M 2 □ <b>Y</b> F	7. Age (In yrs. 53	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day July 17	, 1953	9. Birth Cou Virg	plece (State or F ntry) LNLA	oreign
yland		Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or Lo	cation	·						10d. Inside City	
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h and Menta 7 le marked treumatic ev	၉	19a. Informant's N	Vame/Relationsh			19b. Maili	ng Address	(Street			・ Coたy Route Number		wn, State, Zi	p Code)	
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Department of Importent: If i eny injury or once.		21. Signature of F			1 44	2:	2. Name ar	nd Addre	ss of Facility	Schu		unero	il Home	e of Bel Inc	
S G	cal Examiner	shock, or he immediate Cause disease or condit resulting in death Sequentially list of any, leading to cause. Enter Uncause (Disease othat indiated ever resulting in death	eart failure. List of a (Final ion )  conditions, immediate derlying or injury its	b	o (or as a consec	Mycquence of):			] Ir			OS,		Approximate Interval Betwe Onset and De	
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this certificate has be all director, pege 2 s	a)	25. Was case ref	erred to medical						26. Place	of Death	1 ☐ Yes	2 No	1 Tes	2□ No	_
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Tc the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	I Certi	4  Homicid		g Physician: To the	ding, etc. (Spec	ify)			me. date ar	nd place, a	City or Tow		d manner as	stated.	
he Hos in 24 h he Fun pletely	Medical	(Check only one)	2 Medical	Examiner: On the and ma			nvestigation	n, in my	opinion, dea		d at the time,	date and pla	ace, and due	to the cause(s)	
Tot	2	29b. Signature a	nd title of certifie		11		29	C. Licen	se number	E/ac	1	Λ	)	n, Day, Year)	
/			TO D	7	14				400		)	Aug	ust:	X1,00	$\mathcal{X}$

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	ertificate of D	ealth and Me <i>leath</i>	ental Hygi Re	ene2006	27266
	Physici /Medic		1. Decedent's Name (First, Middle, Las	" Re	1 fus			2. Date of Death Month 08	Day Year 21 2006	3. Time of Death 3:30p M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or L			4c. County of Death	
,¢			2256 Sidney Av		the same to a binder	Baltimo		0.00.40.4	N/A	(0)
	Funeral Director		5. Social Security Number 6. Security Number 219-26-9671  Usual Residence of Decedent		(In yrs. last birthda)		Hours Min.	8. Date of Birth (Month, Day, 15)	Year) 9. Birmp Coun	lace (State or Foreign itry) MD
	/land		10a. State 10b. County		10c. City, Town or I	Location			1	0d. Inside City Limits
	death with the Maryland rma 23s or 28s-f ehow rmst be notified at	tor	MD NA		Baltim	ore				Y☐Yes 2☐No
	ith the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Coun	itry?
	ath w		2256 Sidney Ave				230		U.S.A.	
	er de Itema	Funeral	11. Marital Status	12. Was Decedent Ex Armed Forces?	ver in U.S. 13	. Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spec Mexican, Puerto P	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
336	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan entment of Heatth and Mental Hygiene. ortant: If Item 27 Ie marked other then "natural", or Itema 23s or 28s-1 ehow injury or other traumatic event, the Medical Examinar must be notified at injury or other traumatic event, the Medical Examinar must be notified at 8.	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:		Specify: E	Black
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2	within ene. then "	mple	Elementary/Secondary (0-12)	College (1-4or 5+	) life.	DO NOT use retired)	1 1 51		Gh. !	
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Maryland	should nd Men marke	ဥ	Jake Hammond  19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mai		Kathleer ad Number or Rural		City or Town, State, Zip	Code)
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Z.	of Heror		20a. Method of Disposition		20b. Place of Disc		Da		Oc. Location - City or To	
<u>Ĕ</u>	Pages ment of ant: If It ury or o		1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		Mt.	Zion	8/26	/06 B	altimore,	Md
Baltimore,	permit. Pages 1 a Depertment of Hea Important: If Item any injury or othe		21. Signature of Funeral Service Dicen	Se la	M 4	22 Name and Address arch F/H 300 Wabas	west sh Ave,	Baltim	ore, Md	21215
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	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	1	1.	360011	7.000	Jesi
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Box	death cert e ettendin id for use	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	Fetal death 3	☐Ectopic pregnancy			23d. Date of delive Month	ry Day Year
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မ္မ	6 S C	Completed						24a. Was an autopsy	24b. Were auto	psy findings available inpletion of cause of
=	. The cate h	Con	- 741/0					performe	ed? death?	
Vita	icien Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		1	26. Place of Death			
ō	Phys r this ral dir	٦	1 Yes 2 No 27. Manner of Death	1 Inpatient	2 ER/Outpation		4   Nursing Horr	ne 5 \Lambda Residen 8d. Describe how	ce 6 Other (Specify	′)
Division of Vital Records,	Attending Physicien: r death. ector: After this certific by the funeral director,	to	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	Work?	s 2 No	ou. 90001190 1101	in injury occurred	
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ā	ital or irs efte ral Dir led in	Certification:	4 Tromede	building, etc.	(Specify)			City or Town,	State)	
	To the Hospital or Attending Physicien: The i within 24 hours efter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)  12 Certifying Physical Example (Check only one)	/sician: To the best of iner: On the basis of e and manner state	xamination and/or i	ith occurred at the time, nvestigation, in my opin	, date and place, and occurre	nd due to the cau d at the time, dat	ese(s) and manner as st e and place, and due to	ated. the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier		~	29c. License r	number	290	d. Date signed (Month, I	Day, Year)
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	6		30. Name and address of person who came address of person who came and address of person who came and address of person who	ompleted cause of dea	ith (Item 23a) (Type	Hogith Co	W. 5017	2 Midulo	t. Md.	Nore 21217
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	<sub>.</sub> Registr	ar	AUG 2 9 200	6 Blessen	As Page					

		1 - For State Registrar	State of M	laryland / Der	partment of ertificate of	Health an	nd Mental H	ygiene Reg. No.	2006	27267
Physic /Medi		Decedent's Name (First, Middle, La			6614		2. Date of D Month AUGU	5+ 26	, 2006	3. Time of Death  / 3 J 3 M
Exami	ner	4a. Facility Name (If nod institution, gi Montgomery Gen	eral Hospi	tal	01n				County of Death Montgome	
Funeral Director		5. Social Security Number 6. 217–56–2834  Usual Residence of Decedent	Sex. 7. A 123 M 2□F	ge (In yrs. last birthda 55 Yrs.	y) If Under 1 Yea Months Day		Min. 8. Date of E (Month, I July	22, 1	Cour	place (State or Foreign http://
Maryland a-fehow	ctor	10a. State 10b. County  MD Howa:	rd	10c. City, Town or	Location Glenwoo	d			1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
th with the 23a or 28	Funeral Director	10e. Street and Number 2153 Route 97			10f. Zip Code	1738		10g. Citi	zen of What Cour USA	itry?
THE ZIZIS-UUSO  The filed within 72 hours after death with the Maryland ntal Hygiene.  The differ then "neture!, or Iteme 23a or 28a-f show sevent, tra Madical Exeminat must be netitied at	by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ▓ Divorced	12. Was Decedent Armed Forces' 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Everin U.S. 13 PNo Vietnam	3. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ▼ N		n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Americ Black, White, Specify: Wh	
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fe, Mar 1 and 2 sh Health and tem 27 le m other traum		19a. Informant's Name/Relationship Mr. Gary W. Ridge 20a. Method of Disposition		Son) 215	3 Route	97 Gler	or Rural Route Nurr NWOOd, MD Date	2173	88	
Dattimore, permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		1X Burial 2 Cremation 3 4 Donation 5 Other (Spec	fy)	Mt. Vie	position (Name of lematory or other p w Cemete:	ry 8/	/31/2006	Mar	cation - City or To riottsvi	11e, MD
Depariment of the control of the con	1 0	21. Signature of Funeral Service Lice	Jaiol	A S	ÄIGHT FÜ ykesville	NERAL HO e, MD 21	OME & CHA 1784 (410	PEL )-795	PA (Box -1400	195)
Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as	s a consequence of):  A consequence of):	L SC	ying, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
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hat the de od by the detached		1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant conditions	9 Unknown		Other (specify)		230 Die	t tobogoo u	co contribute to the	ne cause of death?
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the Hosi hin 24 ho the Fund Tipletely f	Medical	29a. Certifier 1 ☐ Certifying P (Check only 2 ☐ Medical Exa one)  29b. Signature and title of certifier	miner: On the basis of and manner s	t of my knowledge, de of examination and/or tated.	investigation, in my	time, date and p opinion, death	place, and due to the occurred at the time	e, date and	place, and due to	the cause(s)
Twit		Poshl A	Ball m	0	D	53317		4.,,	e signed (Month,	2.000
30		30. Name and address of person who	completed cause of	death (Item 23a) (Type O E Rick Rara's Signature	e, Print) #2	13 GAG	tlensburg	MD	2.0877	
Sta Regist	ate rar	31. Date filed (Month, Day, Year)  AUG 2 9 2	006 32 Regist	rars Signature	pour					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygien 2006

	1	State of Maryland / Department of Healt State Registrer  Certificate of Dea	th and Ment a <i>th</i>	al Hygiene Reg. No		2726
Physician		Decedent's Name (First, Middle, Last)	, M	ate of Death Ionth Da		3. Time of Death
/Medical	-	Emil Selby Ruch  A Facility Name (If not institution give street and number)  4b. City, Town, or Local		ust 24,	2006 County of Dea	14:00
Examiner	4	a. Facility Name (If not institution, give street and number)  Carroll Hospital Center  Westmin:			Carrol	
Eupoval	5	Social Security Number 6, Sex 7, Age (In yrs, last birthday) If Under 1 Year If Ur		ate of Birth		thplace (State or Fore
Funeral Director		216-22-8139 1√2 M 2□F 78 Yrs. Months Days Hot	Juns Min. Ju	ate of Birth Nonth, Day, Year, Ly 19, 1	.928	MD
pur A	_	Sual Residence of Decedent  Da. State 10b. County 10c. City, Town or Location				10d. Inside City Lim
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with the Mar t or 28a-f el be notified Director	1	0e. Street and Number 10f. Zip Code		10g. Ci	tizen of What Co	ountry?
th will		9-104 Gaither Manor Drive 21784			USA	
ifter death in terms 23i	1	Marital Status     12. Was Decedent Ever in U.S.     Armed Forces?     13. Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Specify ) exican, Puerto Rican	res or No- i, etc.)	14. Race - Ame Black, Whi	
Swithin 72 hours after death with the Maryland plane.  Then "natural", or Items 23s or 28s-f show tre Medical Ensythete mast be notified at the Medical Ensythete mast be notified at completed by Funeral Director.		1 ☐ Never Married 2 ⚠ Married 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 50€ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Korea	ecity:		Specify:	White
2 hou			most of warking	16b. h	(ind of Business	/Industry
c	2	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)  Muscing Aid			II.o.1 ± h	Como
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should be nd Mental marked o umatic eve		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and N</i>			or Town, State,	Zip Code)
tra tra		Mrs. Glenna L. Ruch (Spouse) 9-104 Gaither M				
Hea Hea then	-	Oa. Method of Disposition 20b. Place of Disposition (Name of	Date	And the second second	ocation - City or	
Se to L		1 \(\sum_{\text{Burial}}\) 2 \(\sum_{\text{Cremation}}\) 3 \(\sum_{\text{Removal from State}}\) \(\sum_{\text{Lake View Mem. Park}}\) 2 \(\sum_{\text{Cemberly}}\) of the (Specify)	8/26/20	06 Syl	esville	, MD
permit. Pag Department Important: I eny Injury o once.		21. Signature of Funeral Service Licensee, HAIGHT FUNER Sykesville,	Facility AL HOME &	CHAPEL,	PA (Bo	x 195)
Physician /Medical Examiner e private and	EXA	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, large, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	, cell c			Marsh
The law requires that the death certificate be site has been signed by the attending physicis cage 2 should be detached for use as the buccompleted by Physician/Medical	пуѕісіапумеці	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No			23d. Date of de Month	elivery Day Year
igne be d	2	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in	Part I.	23e. Did tobacco		to the cause of death? Probably 4 □Unkno
stcian: The law require continuate has been significate has been significator, page 2 should be Completed 1	ompiere			24a. Was an autopsy performed?	prior to death?	
Physician: r this certificatal director, TO Be C	d)	evaminer?	Place of Death Ch	eck on one		
physic this call dire	9	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Nursing Home	5 Residence Describe how inj		ecify)
ding P. After I funera	0	27. Manner of Death  1 S Natural 5 Pending (Month, Day Year)  Natural 5 Pending (Month, Day Year)  Natural 1 S Natural 1 S Pending (Month, Day Year)  Natural 1 Yes		Describe now in	ary occurred	
tal or Attending P rs after death. al Director: After t ed in by the funera	rtilicat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. I	Location (Street a City or Town, Sta		Rural Route Number.
	Medical Ce	29a. Certifier  (Check only one)  1	late and place, and on, death occurred a	due to the cause( t the time, date a	s) and manner and place, and du	as stated. ue to the cause(s)
thin 2 the mpter	Mec	one) and manner stated.  29b. Signature and title of certifier 29c. License nur	mber	29d. D	ate signed (Mor	nth, Day, Year)
T N N N N N N N N N N N N N N N N N N N		Thomas K- Golucia me D316	060	8	125/20	20E
10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	er Aven	IVR L	NESMA	U STELL MA
State	e Ir	31. Date filed (Month, Day, Year)  AUG 2 9 2006  32 Registrar's Signature				

Ub-Ub284 Please Type or Print in Black Indelible Ink Timothy Paul Rogers State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registra 2. Date of Death 1. Decedent's Name (First, Middle Last) Physician/ Month Day August 22, 2006 Timothy Rogers 1126 hrs Pau1 **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimpre City 1121 Hull Street 5. Social Security Number If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Days Hours 9/13/1932 Director 212-30-0991 MD 73 Country) 1 X M 2 F Yrs Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MD Baltimore City Baltimore or 28a-f show notified at once, Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country 1121-1123 Hull Street 21230 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black must he Armed Forces? White etc. 1 Never Married 2 Married 1 X Yes 4 X Divorced Yes, Give Year Yes 2 X No specify: white Widowed Specify: item 27 is marked other than "natural", traumatic event, the Medical Examiner ð 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 Inen of Health and Mental Hygiene ant: If iten 27 is marked other than "to or other traumatic event, the Medical E Business Owner 21215-0036 12 Self-employed 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Virginia Be Timothy Rogers 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8374 Williamstowne Dr., Millersville, MD 21108 Mr. Mark Rogers / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State timore, Chesapeake Cremation Burial 2 X Cremation 3 Removal from State 8/25/2006 Stevensville, MD Department o Important: injury or oth Donation 5 Other Specify 22. Name and Address of Facility Singleton Funeral Home P.A. gnature of Funeral Service License M01364 Second Ave SW Glen Burnie MD 21061 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical UNPENDED AMENDED attending physician or use as the burial of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Month Day past 12 months? Pregnant at time of death Dther (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? certificate bector, page ✓ Yes 2 2 No No 1 🗸 Yes 25. Was case referred to medical 26 Place of Death (Check only one) To the Hospital or Attending Physician: Be examiner? Hospital 1 Dther<sub>4</sub> Inpatient 2 ER/Dutpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 1 V Yes 28c. Injury at Work? After 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 V Natural Division 1 Yes 2 No Pending the 2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) within 24 hours a To the Funeral I determined (Specify) Homicide Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 23, 2006 , my 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

AUG 2 9 2006

**ORIGINAL** 

egistrar's Signatur

State of Maryland / Department of Health and Mental Hygieney 27270 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Pauline Jessie Rice 25, 3:00 A M August 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Timonium Stella Maris Hospice Ctr. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Days 1 □ M 2 🔂 F 216-40-1097 Yrs. Director April 4,1928 England 78 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f ehow the Medical Exercitive must be notified at Dundalk 1 ☐ Yes 2 No Maryland Baltimore Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō United States or itsms 23a 518 South 47th Street 21224 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No þ Specify: 3 Widowed 4 □ Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Lever Brother's Corp 3 Years other treumatic event, parmit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is marked other any injury or other treumatic event once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Leah Barzilay Hyman Salafus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5625 Sykesville Road Sykesville, Maryland David Behe (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ty Burial 2 ☐ Cremation 3 ☐ Removal from State 8/28/2006 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland ailte 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HODGKINS LYMPHOMA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) physicien Box 68760. Physician/Medical use as the cate has been signed by the attending posses 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? ertificate has 2X No 1 ☐ Yes 2 ☐ No 1 Yes Vital Physician: Be 25. Was case referred to medical funeral director, 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this ŏ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division 1 X Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: , 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 0 within 24 hours a
To the Funeral C
completely filled Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

DHMH 17 Rev 1/2001

3:00 a.m.

25,

AUGUST

PAULTNE RICE

State of Maryland / Department of Health and Mental Hygien 2006

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<b>C</b> .	- 1	-	- 1	

For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 22, 2006 Aug. 12:15 AM Elizabeth Rittler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Dundalk Genesis Heritage Meridian Ctr. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 235-46-3871 1 ☐ M 2 🖾 F 74 Nov. 5,1931 West Virginia Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show e filed within 72 hours after death with the Maryla al Hygiene.
other then "nature!", or Itsms 23a or 28a-1 shovent, the Medical Examiner must be multiled at 1 TYes 2X No Dundalk Baltimore Director Maryland 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21222 United States 1919 Guyway 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: **X**Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Assembly Line Worker 9 Years permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othing ry Injury or other traumatic svent, sonce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dora Perkins Robert Woofter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vienna, VA 22181 Denise L. Sylvester (Daughter) 9944 Woodrow St. Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 8/26/2006 Middle River, MD 4 ☐ Donation # 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signatur of uneral Service Licensee, 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) ATHERO SCIEROTIC CARDIOVASCRICAR **Physician** /Medical **Examiner** HABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and P YPERTENSION
Due to (or as a consequence of): Box 68760 HYPERLIPIDEMIA Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by THEOMBOLY TOSIS 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 □ No 1 Yes 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check on vone Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 1 DNatural 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: Aft
completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To Contlying Physician: To the heat of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Savinder CTULA: MD

ame and address of person who completed cause of death (Item 23a) (Type, Print)

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O D 27188 Place Dundalk MD 21222 5 32. Registrar's Signature 31. Date filed (Month, Day, Year)
AUU 2 2 2006 State Registrar

_			1 - State of Maryland / De State of Maryland / De Registrar	ertificate of Death		200b	21212
2	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Media	cal	George Earl Reuling  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		20, 2006 4c. County of Death	1330 p. <sup>м</sup>
30	Examir	ner	58 Gerard Avenue	Timonium		Baltimo	re Co.
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		8. Date of Birth		lace (State or Foreign
-	Director		216-44-2481 1X № 2□F 60 Yrs	. World Days Hours Will.	8. Date of Birth (Month, Day, ) Aug. 27, 1	945 Mar	ÿĨand
	and and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	Location		1	0d. Inside City Limits
	Mary f eho	tor	Maryland Baltimore Co. Timo	nium			1 ☐ Yes <b>¾</b> (∑No
	r 28a	irec	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cour	itry?
	th wit	al D	58 Gerard Avenue	21093		United Sta	tes
	teme	uner	Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerlo</li> </ol>	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	rs afte	y Fi	1 Never Married 2 Married 1 Yes, 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Whi	
21215-0036	within 72 hours after death with the Maryland ane. than "neturel", or iteme 23s or 28s-f show in Madical Examinat musits invilled at	Completed by Funeral Director	15 Decedent's Education 16a De	cedent's Usual Occupation	16	6b. Kind of Business/Inc	
215	thin 7 e.	nple	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of work e. DO NOT use retired)	king		
	filed wi Hygien other th		12 5+	Attorney		Law	
Maryland	ntal H od ot	Be	17. Father's Name (First, Middle, Last)  Earl George Reuling	18. Mother's Nam	Agnos F	aiden Sumame) Baxter	
2	should nd Me mark matic	2		alling Address (Street and Number or Ru			Code)
S	nd2 stith ar			6 Worthington Heigh			
Je,	of Heg		20a. Method of Disposition 20b. Place of Di	sposition (Name of crematory or other place)		c. Location - City or To	
Ē	Pages ment of ant: if it ury or o		4 Donation 5 Other (Specify)  Dulaney		24,2006	Timonium,	Maryland
<b>Baltimore</b> ,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or iteme 23a or 28a-f show enty injury or other treumatic event, the Madical Examinar must be notified at ODGs.		21. Signature of Fune at-Senuce Licensee Michael E. Canapp	Leonard J. Ruck,		305 Harford altimore, M	
68760,	Physician /Medical Examiner bulleting by sician and physician and the printing the	fedical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. A public leads of low to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):	tic Condibuascu	bas Dis	oaso	Onset and Death
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ry Day Year
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Records,	The law requii cale has been s page 2 should	Completed			24a. Was an autopsy performe	prior to cor	psy findings available inpletion of cause of
Vital	ysician: This certificate director, pag	Bec	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)	110	200110
of <	Physical this call direction	မ	1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa			ce 6 □Other (Specify	)
n C	ding Ph h. After th funeral	lon:	27. Manner of Death  1 Natural 5 □ Pending  28a. Date of Injury (Month, Day Year)  Inju  Inju  Inju	y Work?	28d. Describe how	injury occurred	
Division	Attending Physician: ir death. ector: After this certificaby the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm.		28f. Location (Stre	et and Number or Rura	I Route Number
Div	al or safter	Serti	4 Homicide Getermined building, etc. (Specify)	,	City or Town,	State)	,
	To the Hospital or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the fu	edical (	29a Confiler (Check only one)  1 Certifying Physician: To the best of my knowledge 3 2 Medical Examiner: On the basis of examination and/o and manner stated.	eath construct at the time, date and place, rinvestigation, in my opinion, death occur	and due to the cau- red at the time, date	eo(e) and manner as st a and place, and due to	the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month, I	Day, Year)
	2	,	thetautith (W) Deputy	018667	A	ugust 21,	2006
	2	10	30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	. ا ا	17 010	0.5
4.50	CA-	10	31. Date filed (Month, Day, Year) 32. Registrar's Signature	en.11 CT. Luther	uille, M	10 510	43
3	Sta Registr		AUG 2 9 2006	and s			

State of Maryland / Department of Health and Mental Hygienes 27273 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician August Carroll F. Remley, Jr. 2006 9:37 р м /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1719 Lynncrest Road Lutherville Baltimore If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 26, 1 Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F 77 218-26-7338 Director Yrs. 1929 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. Count item 27 is marked other than "naturel", or iteme 23s or 28s-f show other traumatic event, the Medical Examinar must be motified at 10d. Inside City Limits Md. Baltimore Lutherville Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1719 Lynncrest Road 21093 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: SpecifyWhite 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 0wner Advertising Firm 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill trent of Health and Mental H: 18. Mother's Name (First, Middle, Maiden Surname) Carroll F. Remley, Sr. Irene Thelma Yates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Elaine E. Remley/ Wife 1719 Lynncrest Road Lutherville, Md. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of himportent: if ite any injury or ot once. 1 XBurial 2 Cremation 3 Removal from State Dulaney Valley Mem. 9-1-06 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Md. 21. Signature of Funeral Sorvide Licens Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or jach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence) certificate be executed signed by the attending physicien and I be detached for use as the burlal-transit Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cete has been signification control to page 2 should t Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificete 1□ Yes 2 1 Yes 2 No Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 PNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death. To the Funerei Director: After this completely filled in by the funeral dir 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending 2 Accident investigation 1 TYes 2 TNo 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number

D 5578 406 29b. Signature and title of certifier 42. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 9 2006 Registrar

		For State Registrar	State of M	iai ylall	Cer	tificat	e of L	Death		Re	g. No.	106		
ysicia	an	1. Decedent's Name (First, Middle, Las Marie Chris		35						2. Date of Death uqu's t		00 <del>′6</del> ªr	3. Time of Death 6:20 p	
Medic camin		4a. Facility Name (If not institution, give Stella Maris					Town, or	Location o	of Death			y of Death timore		
neral ector		313 22 3030	ex	ige (In yrs. 81	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min. A	Date of Birth (Month, Day, pril 6,	<sup>Y</sup> °¶'925	9. Births	place (State or Forei	
iffed at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Glen Arm										10d. Inside City Limit		
at be no	ai Director	10e. Street and Number 11229 Glen Arm F	Rd.			10f. Zip	Code 1057			10	og. Citizen of What Country? USA			
Examiner	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 X Divorced	12. Was Deceden Amed Forces 1 Yes 27 If Yes, Give Year or Dates	No No	1	<ul> <li>13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> <li>1 ☐ Yes 2 ☑ No Specify:</li> </ul>					14. Race - American Indian, Black, White, etc. Specify: White			
ery injury or other treumatic event, the Madical Exaculner court be notified at once.	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)		5+)	(Give	kind of woi OO NOT us	ork done during most of working se retired)				6b. Kind of I	d of Business/Industry		
IIIC eveni,	To Be C	17. Father's Name (First, Middle, Last) Clarence Griff						18. Mothe H <b>il</b>	rs Name ( da M	First, Middle, M lorton	aiden Suma	me)		
er treuma		19a. Informant's Name/Relationship (Patricia Shepley		r	19b. Mailin 112	g Address 29 G1	(Street a	nd Numbe rm Rd	G G G	Poute Number. en Arm,	Gity or Town Md. 2	1057 <sup>zic</sup>	Code)	
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			Place of Dispo- emetery, cren 1top Se	ervic	ther place e Co	•	8-29-	∙06	Oc. Location TOWSO	n, Md		
9000		21. Signature of Funeral Service Licen	18		22	Name an	Addres W8¥	s of Facilit RORd F	<sup>ั</sup> น <del>ท</del> ุธพูธ	lon Homa:	<b>½120</b>	4		
	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  LIVER DISEASE  Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.												
	hysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant	2 Feta	I death 3	Ectopic pr Other (sp						ate of delive onth	ery Day Year	
3	by P	Part II. Other significant conditions o	ontributing to death	but not res	ulting in the ur	iderlying ca	ause give	n in Part I.			acco use con	itribute to th	ne cause of death?	
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	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2 🗆	ER/Outpatien	3□ 00	Othe			Check only one		har /Caacil	) HOSPICE	
o in by the luneral o		27. Manner of Death  1   Natural  2   Accident  3   Suicide  6   Could not by	28a. Date of Ing (Month, D	ury ay Year)	28b. Time of Injury	M 2	8c. Injury Work 1   Y		28 No	d. Describe hov	v injury occu	rred		
	OF	4 Homicide determined	building, e	etc. (Specify	v)					City or Town,	State)		Il Route Number,	
compreheny mad in	edical		ysicien: To the bes niner: On the basis and manner s	of examina	tion and/or inv	estigation,	in my op	e, date and inion, deat	place, and	at the time, dat	ise(s) and m e and place.	anner as si , and due to	tated.  the cause(s)	
СОЩ		29b. Signature and title of certifier				29c	License	number $372$	-5-	29	d. Date signs	ed (Month,		
1		30. Name and address of person who	completed cause of	death (Item	1 23a) (Type, I	Print)							-	

DHMH 17 Rev 1/2001

AUGUST 26, 2006

MARIE ROSS

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Z0:00 M /Medical uth 25 2006 August 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hopkins Baltimore Johns Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 225.20.2556 1 ☐ M 2 🖫 F Yrs. Director -10.1926 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iteme 23a or 28s-f ehoventh injury or other traumatic event, Tra Medical Examinar must be notified at once. MD Baltimore Director 1 ☑Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2700 Mura Street 21213 USA Funerai Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mano If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: 3 XWidowed 4 □ Divorced Black 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

NUISES ASSI'Stant 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health Care 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elsie Winston Jevinniah towikes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) any M. Stokes Son Baltimore MD 21213 2700 Mura Street 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 09/02/06 Keusville) Union Cameter Vaughil Greene Fyneral Senvices 4905 York Road Baltimore NID 21212 21. Signature of Funeral Service Licensee M01363 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock; or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ardiovasc 30 minutes /Medical Due to (or as a consequence of): Examiner lyocard Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ed by the attending a IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ certificate has been si rector, page 2 should I Be Completed pertension 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1□ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ţ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's

AUG 2 9 2006

Santosh Commen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

600 North Wolfe Street,

Baltimore, Maryland 21287

			For State Registrar	State of Maryland		nent of Health and cate of Death		ene 2006	27276
	Physici	an	1. Decedent's Name (First, Middle, Last)	<u> </u>			2. Date of Death		3. Time of Death
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	Funeral		Social Security Number	7. Age (In yrs. las	t birthday) If U	Inder 1 Year If Under 24 Hrs hths Days Hours Min.	, (Month, Day,	Year) 9. Birthp	place (State or Foreign
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7	anyland show		10a. State 10b. County		Town or Location	1		1	0d. Inside City Limits
4	the Mar 28a-18	Director	Maryland Anne Aru	indel		ibrills			1 □ Yes 2 → Mó
5	with the or 2	Dire	10e. Street and Number 1083 R+3 N	orth Lane		f. Zip Code 2105 Y	10	g. Citizen of What Cour	ntry?
(0	death with the Maryla oms 23e or 28a-f shov if must be notified at	Funerai	103 1113	Was Decedent Ever in U.S.		Decedent of Hispanic Origin? (S specify Cuban, Mexican, Puer	pecify Yes or No-	14. Race - Americ	
~ %	or the	by Fu	1 Never Married 2 Married	Amed Forces?  1 Yes 2 Yo  If Yes, Give		specify Cuban, Mexican, Puenes 22 No Specify:	o Hican, etc.)	Specify: 31	
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V) 2	2 should and Men is marke	F	19a. Informant's Name/Relationship (Type,			dress (Street and Number or Ru			
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Red times	ages 1 nt of H : If its		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem	noval from State	e of Disposition netery, crematory	(Name of or other place)		Oc. Location - City or To	
į	permit. Pages Department of I important: If its eny injury or or once.		4 Monation 5 ☐ Other (Specify)  21. Signature of Funeral Service Lio Insee	Anat	OMYG TH	s Registry Augus	odomu Gifts	Registry	1 1915
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	Physician /Medical	i y	Immediate Cause (Final disease or condition resulting in death)	Renalf	ailure				Onset and Death
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Box	eath certifi	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnand 1□Live birth 2□Fetal d	eath 3 Ector	pic pregnancy		23d. Date of delive	ory Day Year
0	Attanding Physicien: The law requires that the death certificate be executed to death.  To death.  scrotc. Heter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐Unknown	th 5□Othe	or (specify)		MORE	Day 16ai
۵	es that thighed by be detact	y Ph	Part II. Other significant conditions contrib	outing to death but not result	ng in the underly	ing cause given in Part I.	23e. Did toba	acco use contribute to th	ne cause of death?
rde	equire equire en sig	ted b					1 🗌 Yes	2 No 3 Prob	ably 4 Dunknown
Division of Vital Records	siawr has be e 2 sh	Completed					24a. Was an autopsy	prior to cor	psy findings available inpletion of cause of
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0	ng Ph Iter thi	on: T	27. Manny of Death  1 Matural 5 Pending		Bb. Time of Injury	28c. Injury at Work?	28d. Describe how		//
<u></u>	ttandi death. ctor: A / the fu	icati	2 Accident Investigation	One Diese of trive. At hem	M		Of Leasting (Ctra	at and Number of Dura	18
<u> </u>	- 225	Certification;	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, iarm, street, ia	Ictory, office	City or Town,	et and Number or Rura State)	i Houre Number,
	To the Hospital or Attanding Physicien: The law requirements to the Hospital or Attanding Physicien: The law requirements of the Hospital Offsetor: After this certificate has been sit completely filled in by the funeral director, page 2 should in the funeral director, page 2 should in the funeral director, page 2 should in the funeral director, page 2 should in the funeral director, page 3 should in the funeral director, page 3 should in the funeral director.	Medical C	29a. Certifier 1 Certifying Physici (Check only one) 1 Medical Examiner	ian: To the best of my knowle : On the basis of examination and manner stated.	edge, death occu n and/or investig	rred at the time, date and place ation, in my opinion, death occu	, and due to the cau rred at the time, dat	rse(s) and manner as st e and place, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		- 11	29c., License number	290	d. Date signed (Month,	Day, Year)
	_		Heory C.	Wills	IND.	C9(1) 1	A	ugust 28	12006
	/		30. Name and address of person who comp	heled cause of death (Item 2	3a) (Type Print)	pital Drive, (	Hen Bu	rnie, MD,	21061
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatur		el o			
	Registr	ar	AUG 2. 9. 2008	Maring A	for the said	C. C.			

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND TTEM/7, perFH, G860, 10/27/06, WS
State of Maryland / Department of Health and Mental Hygiene

2006 For Stete Registrar 27277 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year 9:58 A.M August 25, 2006 Chasouaneng Yang Sesum /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County 2110 Dulaney Valley Road Timonium If Under 1 Year If Under 24 Hrs. 5. Social Security 8 704 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 1,1924 Birthplace (State or Foreign Country) **Funeral XX**M 2□ F 579-02<del>-8464</del> Director 82 Yrs Laos Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any filury or other traumatic avoir than "natural" ~ " DEPARTMENT OF THE TRAUMATIC AVOIR THE TRAUMATIC A 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Timonium 1 ☐ Yes 24 No Maryland Baltimore County Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 2110 Dulaney Valley Road United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify Specify: Laotian 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Yasa Sesum Si Suomphon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miss Chanpheng Sesum (Daughter) 2110 Dulaney Valley Road Timonium, Maryland 21093 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Evans Funeral Chapel Sept.03,2006 • 4 □ Donation 5 □ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Peaceful Alternatives Funeral&Cremation Ctr.,P.A 2325 York Road Timonium, Maryland 21093 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final ar KINSONS **Physician** sease disease or condition resulting in death) ears /Medical Due to (or as a consequence of) Examiner reas e med Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 250 No 1 Yes 1 Yes 2 X No or Attending Physiclan; director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident (he 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital owithin 24 hours a To the Funeral C 29a. Certifier ↑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainler as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August. 30. Name and address of person who completed cause of death ( tem 23a) (Type, Print) Road Valley TIMMIUM MD 21093 EINESTING 300 Dulaney 2 31. Date filed (Month) Day ( 32. A gistrar's Signature State 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 27278 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician SEIBE 2006 UGUST 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARBOR BALTIMORE 105171 TAL If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan.6,1933 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 73 218-28-6450 Yrs. Director Baltimore, MD Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f ehow amy injury or other treumatic event, The Madical Examples main the rectified at once. MD 1 Yes 2 No Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1149 Haubert Street 21230 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Harbor Hospital Receptionist 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anton W. Ballwanz Lydia F. Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig A. Seibel/Son 890 Arnold Road Westminister, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) August 30, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 4 □ Donation 2/☐Cremation 3 ☐Removal from State Cedar Hill Cemetery Baltimore, MD 5 ☐ Other (Specify) 2006 21. Signature of Funeral Fervice Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Ave. Baltimore Md. 21230 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): physiclen at s the buriat-1 Box 68760, Physician/Medical as IF FEMALE: USB USB 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No ō Month Day 4 Pregnant at time of death 5 Other (specify) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ EURAL EFFUSION 3 Probably 4 Unknown icete hes been sig 1 Yes 2 No Be Completed HYPOTHYROIDISM 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy MONARY this certificete 2 No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ဥ 28a. Dite of Injury (Month, Day Year) 27. Manner of Death Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 □ Yes 2 □ No death. 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 | Homicide Hospital 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) th E 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-7265 7265 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANG PINK JIA HARBOR 3001 South Anover 4. 0 ITAL 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 2 9 2006 Registrar

		For Amend #4a Per State Registrar	State of Maryla	ind / Depa FH G8 Cer	tificate	of the	ealth and M Death	lental Hyg	iene200	6	27279
Physici	- 61	1. Decedent's Name (First, Middle, Last)  George W. S	cott					2. Date of Deat	h		3. Time of Death 07:57am м
/Medic Examir	ner	4a. Feeling Name (If not institution, give st. 725 Glen Drive	reet and number)		,		Location of Death tminster			Carr	
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yi	s. last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apr 26,	Year) 1946	9. Birthp Coun M	lace (State or Foreign try) D
anyland ahow	ō	Usual Residence of Decedent		City, Town or Lo	cation estmil	nste	r			1	0d. Inside City Limits 1 ☐ Yes 2 🎇 No
with the M is or 28s-f	Director	10e. Street and Number 728 Glen Drive			10f. Zip (	Code 211	57	1	10g. Citizen of What Country? USA		
Baltimore, Maryland Z1Z13-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Modical Exaction must be notilised at any injury or other traumatic.	by Funeral		2. Was Decedent Ever in Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: Viet		Was Deceder f Yes, specif	ty Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		, White,	
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and 2 shou eith and N 27 is man		19a. Informant's Name/Relationship (Type Mrs. Shirley Scott	(Spouse)	728 G	len D	rive	and Number or Rui e Westmin	ster, MD	21157		
Saltimore, bermit. Pages 1 ar Depertment of Hee mportant: if item any injury or othe		20a. Method of Disposition  1 \( \frac{1}{N}\)Burial 2 \( \subseteq \text{Cremation} \) 3 \( \subseteq \text{Re}\)  4 \( \subseteq \text{Donation} \) 5 \( \subseteq \text{Other} \( (Specify) \)			sant (	ceme	etery 8/3	0/2006		MD	
permit. Depertition imports		21. Signature of Funeral Service License	- House				ERAL HOM , MD 217			(Box	195)
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Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a con								
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DIVI To the Hospital or At within 24 hours eiter of To the Funeral Direct completely filled in by	edical (	29a. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the best of my ner: On the basis of exa- and manner stated.	knowledge, dea mination and/or i	th occurred nvestigation	at the tir , in my c	me, date and place pinion, death occu	irred at the time,	date and place, a	ind due	to the cause(s)
Totl withii Totl	W	29b. Signature and title of coarrier	200	HOR. M	1BA 290	C. Licens	6e number	83	29d. Date signed 8 28	Month	, Uay, Year)
2		30. Name and address of person who co	A 10 N	DI GRE	SUS	71	7 MET BA	DICAL	CEN!	(ER	1201
S Regis	tate trar	31. Date filed (Month, Day, Year)  AUG 2 9 2006	32. Registrar's S	G GOO	de						

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Z Sãg Z	19a. Informant's Name/Relationship (Type, Print)  Mr. Ronald Sparks (Son)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  4020 Baker Lane, Nottingham, MD 21236	
Itimo it. Pege influent o influent: if	20a. Method of Disposition  1 Date  20b. Place of Disposition (Name of cemetery, crematory or other place)  4 Donation 5 Other (Specify)  21. Signature of Fineral Service Lipersee  20b. Place of Disposition (Name of cemetery)  20c. Location - City or Town, State  20c. L	
Da perm Department on the perm impound on the	9705 Belair Rd., Baltimore, MD 21236	eximate
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₹ 25 £ E	3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier	Number,
To the Hospital within 24 hours a Completely filled completely filled	29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Ye.)	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Hie Hill 1000 Frank in Square  M. D. D. D. D. D. D. D. D. D. D. D. D. D.	
State		7

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	Physicia	_	1. Decedent's Name (First, M	iddle, Last)	-								2. Date of Dea August	ith			3. Time of Dea 7:13 a	
	/Medic	al .	Otto W. Schau						4h Cih	Town or	Location of				County of		7 • 15 G	194
	Examin	er	a. Facility Name (If not instituted in the Marley Neck I								ırnie	i Deali			nne .		del	
	Funeral Director		5. Social Security Number 212-07-3759	6. Sex			(In yrs. la:	st birthday) Yrs.		r 1 Year Days	If Under: Hours	Min.	8. Date of Birt (Month, Day Jan. 5,	Year) 191	9	Coun	ace (State or Fo try) Land	reign
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	deat	ner	11. Marital Status		2. Was De	Forces?		. 13.	Was Dec	dent of H	ispanic Ori	gin? (Sp.	ecify Yes or No Rican, etc.)			- Americ White,	an Indian, etc.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show supprignt: If item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, Ir.s Medical Examinar traint the notified at once.	Completed by Funeral	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo		1 ⊠Yes If Yes, 0 Year or	2 □ N Give	lo	1	1 □ Yes		Specify:				Specify:	whi	.te	
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<u>Z</u>	should nd Mei mark matic	۴	19a, Informant's Name/Relat		oe, Print)			19b. Mailir	ng Addres	s (Street	and Numbe	or Run	al Route Numbe	er, City o	r Town, S	itate, Zip	Code)	
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State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2006 27282 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3:30 A M 2006 August Louise Stahlev /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Brinton Woods Nusring Home Carrol1 Sykesville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 25, 1909 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Country) 1 M 2 TYF 97 Yrs. 412-34-2291 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location in than "natural", or Items 23s or 28e-f ehow the Medical Examiner must be occitied at 1 ☐ Yes 2 ▼No Sykesville Carrol1 Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21784 USA 805 Duchess Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dietary Worker State of MD Peges 1 and 2 should be filed viment of Health and Mental Hygie tent: If item 27 is marked other toury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Trent Betty Rose Thurman Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Howard Ferguson (Nephew) 805 Duchess Drive Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Depertment of Importent: If eny injury or 2005. Lake View Mem. Park 8/28/2006 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee PATGAT AGGS FEAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 Halo Blian Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. D not enter the mode of shock, or heart failure. List only one cause each line. Immediate Cause (Final disease or condition resulting in death) RIMOR Physician /Medical uence of): Due to (or as a cons-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): ettending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death signed by the e 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death bull out resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? erebrovasulan 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes 2 No or Attending Physicien: director, To Be 25. Was case referred to medical examiner? 26. Place of eath Check only one) Hospital: Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA ro the Funeral Director: After this completely filled in by the funeral directors. 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medicai Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier 1 🔂 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On-the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 20806 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14) LURAUS 1000 31. Date filed (Month AUG 2 9 2006 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 27283

		1- For State Registrar	C	Certificate c	of Dea	ath			Re	g. No.		
Physicia		Decedent's Name (First, Middle	,Last)						ate of Death	h		3. Time of Death
çal Exami		Damien Alexan	der Studivant					l A	<sup>r</sup> onth ugust 27,	Day 2006	Year	0546 hrs
)		4a. Facility Name (if not institution			4b. City,	, Town, or	Location of				nty of Death	
		Harbor Hospital			Balt	imore						
Funeral		5. Social Security Number	6. Sex 7. Age (In yr	s. last birthday)	If Un	ider 1 Year	If Under	24Hrs. 8.	Date of Birt	h (MM/DD/Y)	(YY) 9. Birl	thplace (State or Foreign
Director		·			Mon			Min.		,		untry)
5		219-06-7121	1 XM 2 F 21	ıY	S.			0	9/17/	1984	Mar	yland
80		Usual Residence of Decedent  10a. State 10b. County	100 6	City. Town or Loca	tion			A				10d. Inside City Linuts
w any		Tob. County	100. 0	alty, FOWIT OF LOCA	111011							1 X Yes 2 No
and F sho	5	Maryland		Balti	Lmore	2	_					
daryland 28a-f show 1 at once.	ect	10e. Street and Number			10f. Z	ip Code				g. Citizen of	What Cour	ntry?
ith the Maryland 23a or 28a-f sho notified at once.	ᡖ	701 South Cator	Avenue		1	21229	9		Į	J.S.A.		
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	Funeral Director	11. Marital Status	12. Was Decedent Ever in			dent of His	panic Origir		Yes or No-			can Indian, Black,
iten iten	a l	1 X Never Married 2 Ma	rried Armed Forces?		Yes, spe	cify Cuban	, Mexican, I	Puerto Rica	in, etc.)		hite, etc.	
her d		3 Widowed 4 Divo	rced If Yes, Give Year		Yes	2 y No	specify:			Speci	<sub>fy:</sub> Bla	ck
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	d by	15. Decedent's Education (Spec	ify only highest grade completed						done	16b. Kind of	Business/I	ndustry
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-00 d with	Completed	17. Father's Name (First, Middle,	_ast)			1	18.Mother's	Name (Fire	st, Middle, M	laiden Surna		
al Hy	Be	Coomer Chuddaa	- 4				Na	nette	B. Ne	ewmuis		
21215-0036 ould be filed within 7 Mental Hygiene, s marked other than ic event, the Medica	9	George Studiva: 19a. Informant's Name/Relationsh	ip (Type, Print )	19b. Mailir	ng Addres	ss (Stree					own, State	, Zip Code)21225
→ 5 5 5 E	-	Nanatta P Narm	ida / Matham									e, Maryland
e, MC 1 and 2 sl Health ar item 27		Nanette B. Newno 20a. Method of Disposition	IIS / MOLHER	b. Place of Dispo	sition (N	ame of cen		Da				Town, State
Ore ges 1 of H		1 Burial 2 X Cremation	3 Removal from State	crematory or o	ther plac	e)		0-1	0.60			
im. Pag		4 Donation 5 Other Sp		etro Cre	emato	ory 1	nc.	8 2	9-06	Balti	more,	Maryland
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1	21. Signature of Funeral Service I	icensee	22.	Name an	nd Address	of Facility	The De	errick	c C. J	ones :	F/H, P.A.
E. E. G. &	_	War &	C- /2-	46	11 F	ark I	lgts.	Ave.	, Balt	imore	, Mar	yland 21215
Physician		23a. Part I. Enter the disease, or callure. List only one cause		ath. Do not enter	the mode	e of dying,	such as car	rdiac or res	piratory arre	est, shock, or	heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease	a. Gunshot Wound of C	Chest								Death
		or condition resulting in death)	Due to (or as a consequence	e of):								
	_	Sequentially list conditions,	b									
	<u>e</u>	if any, leading to immediate	Due to (or as a consequence	e of):								
1/ -	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):								
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. the the thin and the Funeral Director: After this certificate has been signed by the attending physician and optietely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medical	UNPENDED	x AMENDED 1 per	r me g85	8 8-	29-06	vt					-
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387 rrtific ling p	an/	23b. Was decedent pregnant in the past 12 months?	LI TIAG DILILI	2	etal deat	h 3	Ectopic	pregnancy		Month	n D	ay Year
Box 68 e death certi the attendin ed for use a	흥		Pregnant at time of	f death 5 C	ther (Sp	ecify)				1		
Be der	اخ		9Onknown									
P.O. Box 687 so that the death certific gned by the attending p		Part II. Other significant condition	ons contributing to death but n	ot resulting in the	underlyir	ng cause g	iven in Part	t I.				the cause of death?
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Vital Rec ysician: The his certificate director, page		25. Was case referred to medical				26 Place	of Death (C	Check only		Z NO	1 ✔ Ye	5 2 100
ital iiciar s ceri	Be	examiner?	Hospital: 1 Inpatient 2	✓ ER/Outpatier	ıt 3		Other	Nursing Ho		Residence (	6 Other	
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Division pital or Attent ours after death teral Director:	틥	deter	not be 28e. Place of Injury - A		eet, factor	ry, office bi	unding, etc.	201.	or Town, St	ate) Rd., Balti	mber or Rui	ral Route Number, City
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Division  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Medical		and manner stated.	and or investige				anou at trie	uno, uate a			
	Σ	29b. Signature and title of certifier			29	9c. License					-	th, Day, Year)
	-	Parents StriAns	11.mo			O.C.N	И.E.			August 2	7, 2006	
, 1	ı	30. Name and address of person	who completed cause of death (I	tem 23a)						<u> </u>		
/		Pamela Southall, MD	Assistant Medical Exa	miner 111	Penn S	Street, B	altimore,	, MD 212	201			
S+	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	-	-						
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			for Stata Ragistrar	State of Marylan	Cei	rtificate of L	Death		Reg. No.	006	21284		
	Division		Decedent's Name (First, Middle, Last)	1				2. Date of Dea Month		Year	3. Time of Death		
н	Physici /Medic		Bernard J. Sui				. 11	August	22,	2006	1610 M		
	Examin	er	4a. Facility Name (If not institution, give			,,	Location of Death			county of Death			
	Funeral		Holy Cross Hos  5. Social Security Number 6. Securi		last birthday)	S11ver If Under 1 Year	Spring If Under 24 Hrs.	8. Date of Birt		ont gome	hplace (State or Foreign		
	Director		5/8-30-9159	XM 2□ F 79	9 Yrs.	Months Days	Hours Min.	Apr. 13	, 1001/	00	nington, DC		
	and w		Usuaf Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. fnside City Limits		
	Maryl-f eho	tor	Maruland Mantage	RC.	ckvill	Δ				:	1 ☐ Yes 2 ☐ No		
	r 28e	Directo	Maryland Montgome 10e. Street and Number	ity ito	CKVIII	10f. Zip Code			10g. Citize	en of What Co	untry?		
	23a c	raiD	13402 Grenoble Di			20853				ed Stat			
	er dei	Funeral		12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	I. Race - Ame Black, White			
36	urs aft	ρχ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 MYes 2 No World Yes, Give Year or Dates: War	II I	1 ☐ Yes 2 💢 No	Specify:		S	Specify: Wh	ite		
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az	2 should and Men ie marke	( 8)	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailir	ng Address (Street a	and Number or Rui	ral Route Numbe	r, City or	Town, State, 2	Zip Code)		
	s 1 and 2 should of Health and Men item 27 is marks other treumatic		Beverly A. Miller			Lynn Cre				Maryla ation - City or	nd 21770		
5	Pages in the page of the pant: If ite ury or of		20a. Method of Disposition  14 Burial 2 Cremation 3 F	Removal from State Ga	emetery, crei ite of	matory or other plac Heaven	e)   Augu   2006	Date IST 25,					
Baltimore,	permit. Pages Department of Important: If it eny injury or o	1	4 □Donation 5 □ Other (Specify)  21. Signature 1	.00	Cemet	2. Name and Address	s of Facility Ro	hert A.	Pumn	hrev F	ing, MD uneral Home/		
ñ	Ped m p		1 CarilE !	and. MOC	803 Ro	ckville, ckville,	Inc. 300 Maryland	West M	ontgo 2805	merý A	venue		
			Rockville, Inc. 300 West Montgomery Avenu  23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interviously one cause on each line.  Appropriately Avenu  Appropriately Avenu  Appropriately Avenu  Onset										
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ı	/Medical Examiner		, , , , , , , , , , , , , , , , , , ,	Due to (or as a conseq	·	um and a							
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rds	quires n sign uld be	ed by	Acute Renal Fail	ure				101	′es 2 🗆	No 3∏Pr	obabíy 4½ Unknown		
၀	e law requir hes been si je 2 should t	Completed	Cirrhosis					24a. Was		24b. Were au	topsy findings available comptetion of cause of		
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Zi Zi	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital: **	1	oth oth	26. Place of Dea						
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<u>o</u>	tending death. tor: Afte the func	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Intury		k? Yes 2 □No						
<u>Si</u>	or Attandated of the death of the office of	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st	reet, factory, office		28f. Location (S City or Tox		Number of Ru	ural Route Number,		
Ω	pital or urs afte eret Dir illed in		COn Contilion Physical Physica	relation. To the best of suction		h	data and place						
	To the Hospital or At within 24 hours after or To the Funeret Direct completely filled in by	Medical	29a. Certifier ACCertifying Phy (Check only one)	vsician: To the best of my knoiner: On the basis of examina and manner stated.	tion and/or in	ivestigation, in my o	pinion, death occur	red at the time,	date and p	olace, and due	to the cause(s)		
	To the To the Comple	₹	29b. Signature and title of pertifier	)		29c. License	e number		29d. Date	signed (Monti	h, Day, Year)		
)	, \			<i></i>		D478	367		Augus	t 22,	2006		
1	22		30. Name and address of person who co				Dog1	o Ma	los 1	20050			
	Sta	ate	Oney Zaniga, M.D.  31. Date filed (Month, Day, Year)	4701 Randol 32. Registrar's Signa	him		KOCKVIII	e, Mary	Land_	20852			
	Regist		AUG 2 9 20	06 January	B. A	soule							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Vaar **Physician** Mary Carol Searcy 11:25 A.M 2006 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Anne Arundel 704 Matthews Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 □ M 2**K** F Director 212 58 2413 54 11, 1952 Mary land Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location. 10a. State 10b. County or 28e-f show traumatic event, the Medical Examiner high be notified at 1 Tyes 2 XNo Marvland Director Anne Arundel Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 704 Matthews Avenue U.S. or Items 23a death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filled within 72 hours after and Mental Hygiene.
Is marked other then "naturel", or Ite 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Technician Pharmacy 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Frances Pantelis Roland Carroll Jenkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n eny injury or other traun <u>once.</u> Thomas A. Searcy / Husband 704 Matthews Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery Baltimore, Maryland 8/26/2006 \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature) of Funeral Service Licensee 23a. Part I. Enter the disease, O complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure dist only one cause on each line. 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death Immediate Cause (Final Physician ean disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe Melli abete 2 No 3 Probably 4 Unknown 1 X Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an telywon certificate 2 No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner?
1 \( \text{Yes} \) 2 \( \text{No} \) 26. Place of Death (Check only one) Be Other: Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel 24 hours a 29a. Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date şigned (Month, Day, Year) 29b. Signature and title of certifier 23

State Registrar

SRIDHAR. 31. Date filed (Month, Day, Year)

ATLURI 8109 32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2006

icichie.

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State of Maryland / Department of Health and Mental Hygien 2006 27286 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Karl Joseph Schwarz 5:35 P. August 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Oak Crest Village Nursing Home Parkville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar. 10, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** <sup>Y</sup>923 Maryland Days Hours Min. 1 X M 2 F 83 Yrs. 219 18 4564 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "naturat", or items 23a or 28a-f show other traumatic event, the Medical Examinatings to notified at 1 ☐ Yes 2 🖾 No Maryland Baltimore Director Parkville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8800 Walther Boulevard 21234 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". or lamp injury or other traumant. 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 Specify: White ò 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 2 vears Foreman Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Marie Smith Joseph Schwarz ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marianne Schwarz / Daughter 5 Knaves Court Baltimore, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 8/28/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part Enter the deease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASCV disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year P.O. 5 Other (specify) Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ K:020 0150KSE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificete 2 NO 2 No 1 ☐ Yas 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 잍 27. Manner of Death 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 🖸 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mor 1758646 27 2006 611 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wa Ithe KU:11= MD21234 8800 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 2 9 2006

			For Stat	e of Maryland				Mental Hygi	ene	07007
			= State Registrar		Cert	ificate of L	Death		<sub>9. No</sub> 2006	27287
	Physici	an	1. Decedent's Name (First, Middle, Last)	-/1				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	ai	4a. Facility Name (If not institution, give street an	d number)		4b. City, Town, or	Location of Dea		23, 2006 4c. County of Dea	
ř	Examin	er	7797 Catherine Ave.	o nambor,		Pasaden			Anne Arı	
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hr Hours Mir	(Month, Day,	Year) 9. Birt	thplace (State or Foreign
	Director	ļ	100-16-2719 Usual Residence of Decedent	85	Yrs.			June 19	,1921	New York
	yland how		10a. State 10b. County	10c. City, T	own or Loca	ation				10d. Inside City Limits
	8a-f	Director	Maryland Anne Arunde	1 Pasa	dena			· · · · · · · · · · · · · · · · · · ·		1 Yes 2 No
	with the a or 2		10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	deeth ma 23	Funeral	7797 Catherine Ave.  11. Marital Status 12. Was	Decedent Ever in U.S.	13. W	21122 as Decedent of Hi	spanic Origin? (	Specify Yes or No- irto Rican, etc.)	U.S.A.	
9	ours after deeth with the Marylan ral', or Itema 23a or 28a-f show Examiner must be notified at		1 Never Married 2 Married 1	ed Forces? Yes 2 ☑ No s. Give		res, specify Cubai ⊒Yes 2.EHNo	n, Mexican, Pue Specity:	no Hican, etc.)	Specify: T.Th.	
21215-0036	filed within 72 hours after deeth with the Maryland Hygiene. ther than "natural", or Itema 23a or 28a-f show ther than "natural", or Itema 23a or 28a-f show ent, the Medical Examinat must be notified at	ed by	3 √Widowed 4 ☐ Divorced Year  15. Decedent's Education	or Dates:	6a Decede	nt's Usual Occupa	ation	1	Wh:	ite
215	hin 72 a. an "na Madis	Completed	(Specify only highest grade comple	eted) ege (1-4or 5+)	(Give ki	nd of work done d NOT use retired,	luring most of w )	orking '	ob. Kille of business	mastry
2	e filed wit il Hygiene other the	Com	12 N/		Н	ousewife			Own Home	e
Maryland		Be	17. Father's Name (First, Middle, Last)	C	-11.	_		ame (First, Middle, M	•	livan
Ž	d 2 should be th and Mental 7 is marked freumatic ev	ဥ	George  19a. Informant's Name/Relationship (Type, Prin		cholt 19b. Mailing		Cather and Number or F	TITE Rural Route Number,		en
	# E M =		Kathleen Wawryk (Daug	hetr)	7797	Catheri	ne Ave.	Pasadena,	Maryland	21122
ore	Peges 1 and nent of Healt int: If Item 2 iry or other		20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal	from State ceme	etery, crema	tion (Name of story or other place	· 1		Oc. Location - City or	
Baltimore,	교육분분 .		4 Donation 5 Other (Specify)  21. Signature of Eneral Service Licensee	Crow		le V.A.		28/06	Crownsvil	le Maryland
Ba	Dermi Depa Impo any I		21. Signature of Paneral Service Licensee		Mc	Name and Addres Cully-Po	lyniak	Funeral Ho d Pasadena	me. P.A.	A 01100
			23a. Int1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. I						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	eukemic						Onset and Death
	/Medical Examiner		resulting in death)	e to (or as a consequent	ce of):	· L. <	7 )			
	4.	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e to (or as a consequent	ce of).	istic?	Jyner	she		
	nd A	Examiner	that initiated events c							
/60,	ate be executed ysician and he burial-transit	cal Ex	resulting in death) Last Du	ie to (or as a consequen	ce of):					
/89	7 × 5	_	d							
Š	eath certificat attending phy I for use as the	M/UR	230. Was decedent pregnant	s, outcome of pregnancy ive birth 2  Fetal dea		ctopic pregnancy			23d. Date of del	•
o.	the death certifica y the attending ph iched for use as th	Physician/Med	1 Ves 2 No	Pregnant at time of death Jinknown		Other (specify)			Month	Day Year
J.	that the dened by the solder	Ph	Part II. Other significant conditions contributing	to death but not resultin	ng in the und	erlying cause give	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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X m								perform	ed? death? No 1 ☐ Yes	14
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ַס	g Physical chis	-	27. Manner of Death 28a.		b. Time of Injury	28c. Injury Work		Home 5 Resider 28d. Describe how		ciry)
Slor	ttending I death. ctor: Alter y the funer	catlo	2 Accident investigation	, vicinii, bay i saily			res 2 □ No			
Division	or Att after d Direct in by	Certification:	determined 200.	Place of Injury - At home building, etc. (Specify)	, farm, stree	t, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 12 Certifying Physician: 1	o the best of my knowled	dge, death o	occurred at the tim	e, date and place	ce, and due to the cau	ise(s) and manner as	s stated.
	the Ho in 24 the Fu	Medical		manner stated.	and/or inve					
)	or To Too	2	29b. Signatute and tille of certifier			29c. License	917	29	d. Date signed (Mont	h. Day, Year)
•	6		30. Name and address of person who completed	gause of death (Item 23	Ba) (Type, Pr	rint) V	10,1	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0/24/0	<i>b</i>
	Τ		Jorge 18187-	Alg/2 3-	108	Mount	1 Con	69 Kas	dona 1	10 21122
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	boar					
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			1 10430 1	State of Maryland	Department of Health a	and Mental Hygie	_	
			1 - State Registrar		Certificate of Death	Reg	2006	27288
	Physici	an	1. Decedent's Name (First, Middle, Last)	Thomas		2. Date of Death Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If ogt institution, give s	treet and number)	4b. City, Town, or Location of	AUGUST of Death	4c. County of Death	1,50
			10/2 Claym	ont Ave.	Baltin	10re	N/	4
	Funeral Director		5. Social Security Number / 6. Sex	M 20XF 7. Age (In yrs. last	birthday) If Under 1 Year If Under Yrs. Hours	Min. 8. Date of Birth (Month, Day, Y	9. Birthp	place (State or Foreign htry)
			Usual Residence of Decedent  10a. State 10b. County	10c City To	own or Location	DCC, 1,1	10011110	Od. Inside City Limits
	Maryla I eho	ţō	Maryland N/	A B	altimore.			1 XYes 2 □ No
	or 284	Funeral Director	10e. Street and Number	+ 1.	10f. Zip Code	10g	. Citizen of What Cour	ntry?
	heath v	era	10 & Clay W	2. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Ori	gin? (Specify Yes or No-	14. Race - Americ	can Indian,
36	ours after death with the Marylan rel', or iteme 23a or 28a-f ehow Examiner must be notified at		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	If Yes, specify Cuban, Mexican  1 Yes 2 No Specify:	ř. Puerto Rican, etc.)	Black, White,	etc.
215-0036	72 hours after death with the Maryland "naturel", or iteme 23a or 28a-f ehow citcal Examiner must be notified at	Completed by	3 Widowed 4 Divorced  15. Decedent's Educ	Year or Dates:	6a. Decedent's Usual Occupation	16	b. Kind of Business/Inc	ack dustry
1215	d within 72 ho piene. r then "natur the Madical	mple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during mos life. DO NOT use retired)	t of working	1	7 -/
d 21	illed v I Hygie other t		17. Father's Name (First, Middle, Last)		Manager 18. Mothe	or's Name (First, Middle, Mai	iden Sumame)	surplus
Maryland	Mental Mental arked c	To Be	Julius F	arker	Ju	elia Ho	awkins	>
Mar	s 1 and 2 should be filed I Health and Mental Hyg Item 27 is marked othe other traumatic event,		19. Informan 's Name/Relationship (Ty)	Harmar 1	9b. Mailing Address (Street and Number	or or Rural Route Number, C	ity or Town, State, Zip	Code)
ore,	of Heal of Heal fitem		20a. Method of Disposition  1 Burial 2 Cremation 3 R		of Disposition (Name of etery, crematory or other place)		c. Location - City or To	own, State
Baltimore	ermit. Pages separtment of mportent: If it ny injury or o nce.		4 Donation 5 ☐ Other (Specify)	Kin	a Mem. Parki	15/2006 7	Balto.	Md.
Bal	Department Department Important Irraportant	21. Signature of Funeral Service License	L. Kur	2. Name and Address of Eacility JOSEPH L. KU 2222 W. North	SS Funer	ul Home	P.A.	
	* *		23a. Part   Enter the disease, or compli- shock, or heart fallure. List only on	cations that caused the death. De cause on each line.	o not enter the mode of dying, such as	cardiac or respiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due tevlor as a consequence	myradial	Infantion		Oliset and Death
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Вох (	eath certificat attending phy I for use as thi	an/Me	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1  Live birth 2  ☐ Fetal dea	ath 3 DEctopic pregnancy		23d. Date of delive	*
-	at the deal by the att	Physician/Med	in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	4□Pregnant at time of death 9□ Unknown			Month	Day Year
s, P.O.	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	by Ph	Part II. Other significant conditions con	tributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
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/ital	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?			of Death (Check only one)	NO TO TES	2   140
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ion	Attending F r death. octor: After by the funera	atlor	1 Satural 5 Pending investigation	(Month, Day Year)	D. Time of linjury at Work?  M 28c. Injury at Work?  1 □ Yes 2 □ I	`	.,,	
Division of Vital Records,	P He Fig.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  Certifying Physical Examination (Check only one)	ician: To the best of my knowled er: On the basis of examination and manner stated.	dge, death occurred at the time, date an and/or investigation, in my opinion, deat	d place, and due to the caus th occurred at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of confiler		29c. License number		Date signed (Month, I	Dey, Year)
)			- Mount	ms	030408	3 8	179/06	
	3		30. Name and address of person who co	repleted cause of death (Item 23:	a) (Type, Print) WHSY WOTON RU	D BARROW	sim and	21223
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature		1		4
DH	MH 17 Rev 1/20	- 55	AUG 2 9 200	Janes St.	figure.			

ORIGINAL

				ertificate of Death	fental Hygiei Reg.	2000 21203
	Physici		1. Decedent's Name (First, Middle, Last)  LILLE M. TEMS	A H	2. Date of Death Month	Day Year 3. Time of Death 2:28 PM
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Bod SECOUPS HOSPITAL	Baltana	2F	N A
	Funeral Director		5. Social Security Number  6. Sex 1 M 2 M F  7. Age (In yrs. last birthda  Yrs.  Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 06.06.194	9. Birthplace (State or Foreign Country)  MD
	yland Now		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	a-f et	ctor	MD NA BALTIMO	2E		1 <b>M</b> Yes 2 □ No
	deeth with the Maryland me 23a or 28a-f ehow rmust be notified at	Dire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	• 23a	ral	1310 W. SARATOGA STREET	21223	- 7 \	USA
	ter de	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ₹ No.	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> </ol>	Rican, etc.)	14. Race - American Indian, Black, White, etc.
ဗ္ဗ	72 hours efter naturel', or Ite dical Examina	by	3 ☐ Widowed 4 图 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 <b>©</b> No <i>Specify:</i>		Specify: BLACK
5 0	72 ho	eted	15. Decedent's Education 16a. De (Specify only highest grade completed) (G.	cedent's Usual Occupation ive kind of work done during most of work	ing 16b	. Kind of Business/Industry
21215-0036	filed within Hygiene. sther than "	Completed	Elementary/Secondary (0-12)   College (1-4of 5+)	ive kind of work done during most of work a. DO NOT use retired) MATION ENGINEER		OC KONAMON
	filed Hygie Sther		17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	OF EDUCATION  (en Sumame)
Maryland	permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan Department of Heatth and Menial Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23a or 28a-f ehow any folury or other traumatic event, the Medical Examinar must be notified at anote.	To Be	BILL HOLLMAN	EUZA J	SQUIRRE	ar .
ary	2 should and Men is marke			ailing Address (Street and Number or Run	al Route Number, Cit	y or Town, State, Zip Code)
	and in 27 m 27		WILLE M. JACOBS (SISTER) 1310	W. SARATOGA ST.,	BAUTO. N	
Baltimore,	Pages 1 nent of H int: If Ite iry or ot		1 BB-Burial 2 □ Cremation 3 □ Removal from State cemetery, c	rematory`or other place)		Location - City or Town, State
₽	iit. Pa artmer ortant injury		4 Donation 5 Other (Specify)  21. Sign ture of Funeral Service License		2.06 B	AUTO. MD
æ	permit. Departr Imports any Injt		Dangha C	22. Name and Address of Facility VAUGHN C. GREBUE 5151 BALTO, NATU PIKE	FUNERAL	SER. 10 21229
			23a. Part1. Enter be disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac		Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	hal to E	se to	Onset and Death
	/Medical Examiner		resulting In death)  Due to (or as a consequence of):			
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9	leath certific attending pl	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			
Вох	atten for us	clan	in the past 12 months?	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery  Month Day Year
P.O.	that the death cer ed by the attendir detached for use	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	o li o i i di discony)		
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of Vital Records	g Physiclen: The law requir er this certificate has been si eral director, page 2 should	To Be Completed	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat  27. Manner of Death 28a. Date of Injury, 28b. Time	26. Place of Deat ient 3⊞eOA Other: 4 Nursing Ho	1 Yes  24a. Was an autopsy performed 1 Yes 2 A	2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 CLA
ion of Vital Records	nnding Physicien: The law requir ath. rr: After this certificate has been si ne funeral director, page 2 should	To Be Completed	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	26. Place of Deat	1 Yes  24a. Was an autopsy performed 1 Yes 2 Arch (Check only one)  me 5 Residence	2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 CLA
ivision of Vital Records	or Attending Physicien: The law requir ter death. Irector: After this certificate has been si n by the funeral director, page 2 should	To Be Completed	25. Was case referred to medical examiner?  1   Yes   2   No	26. Place of Deat  ient 3 2 6. Cther: 4 Nursing Ho  of 28c. Injury at Work?  M 1 Yes 2 No	24a. Was an autopsy performed 1 Yes 2 1 h (Check only one) ome 5 Residence 28d. Describe how in	2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Ves 2 Land
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		•	For State Registrar	State of Mary	yland / L	epartmer <i>Certifica</i> :	t of He e of D	eaith and iv <i>Peath</i>		giene Reg. No.	2006	27290
	Physici	an	1. Decedent's Name (First, Middle, Last	")		him		***************************************	2. Date of Dea	Day	24 200	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			Town, or l	ocation of Death	Augu		County of Deat	
	Funeral Director		5. Social Security Number 6. Se	OKINS HOS	dyrs. last birt	hday) If Under	r 1 Year	If Under 24 Hrs. Hours Min. Febru	8. Date of Birt (Month, Da ary 20.	h y, Year) 193	n/a  9. Birtl Co Ohi	hplace (State or Foreign untry)
	D		Usual Residence of Decedent  10a, State 10b, County	10	0c. City, Town	or Location						10d. Inside City Limits
	Maryla I-f ehor	to	Florida Collier		Nap1							12 Yes 2 No
	or 28s	Director	10e. Street and Number				Code			•	zen of What Co	
	ne 23e	Funerai	413 Knotwood Lane	12. Was Decedent Eve	er in U.S.	1	4112-				d State	s of America
900	ours after d rei', or iten	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:		If Yes, spe		panic Origin? (Sp , Mexican, Puerto Specify:	Rican, etc.)	1	Black, White Specify: Whi	
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23s or 28s-f show say injury or other treumatic event, the Medical Exarts at must be usuffied at ance.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th	completed)  College (1-4or 5+)		Decedent's Usu (Give kind of we life. DO NOT u Sewife	ork done du	tion uring most of work	ing		nd of Business/	Industry
<u>م</u>	il Hygi other	Be Co	17. Father's Name (First, Middle, Last)	0	nou	DEWITE		18. Mother's Nam	e (First, Middle,			
ylar	Menta Menta Arked	To B	LeRoy Manrod						Everman			
	alth and 2 Sho	To Act of the Control	19a. Informant's Name/Relationship (7 James J. Thim	ype, Print) (Husband)		•	,	ane, Nap				
Baltimore,	Pages 1 e		20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemeter	Disposition (Na y, crematory or Cremato	other place	) !	Date 2006		cation - City or imore,	Town, State Maryland
Balti	permit. Depertm importa eny inju		21. Signature of Funeral Service, Licens	500		22. Name a	nd Address	_	ing Bye	rs F	uneral	Directors,In
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the								Approximate Interval Between
)	Physician		Immediate Cause (Final disease or condition resulting in death)	. Seps	515	of un	Knon	un eti	ology			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence	of):						
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a c	onsequence (	oř):						
	execute n and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	onsequence o	of):						
68760,	ficate be executed physicien and is the burial-transit	edicai	· ·	d.							-	
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcome of particles of the second of the se	Fetal death	3 □Ectopic p 5 □ Other (s			W	2	23d. Date of del Month	ive <b>ry</b> Day Year
	res that signed by be deta	þ	Part II. Other significant conditions of	ontributing to death but r	not resulting in	the underlying	cause giver	n in Part I.		obacco u Yes 2[		the cause of death?
cord	w require been si should I	ieted							24a. Was			
Division of Vital Records,	The la ate has page 2	Completed							autor perfo	rmed2	death?	itopsy findings available completion of cause of 2 No
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Other	26. Place of Deal				
ð	Phys ar this eral dir	7: To	27. Manyer of Death	1 N Inpatient 28a. Date of Injury (Month, Day Y	2 □ ER/Ou 28b. T		OA 28c. Injury Work'	4   Nursing no	ome 5 ☐ Resident			cify)
sion	eath. or: Aft	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		ear) II	njury M		es 2 No				
Ö K	al or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (		rm, street, facto	ry, office		28f. Location (: City or Tox			ural Route Number,
	o the Hospital or Attending Physician: The lavible 24 hours after death.  o the Funarai Director: After this certificate has ompletely filled in by the funeral director, page 2	edicai (		ysician: To the best of r iner: On the basis of ex and manner stated								
	To the To the To the Complet	Ň	29b. Signature and title of certiflet			29	c. License	number		29d. Dat	e signed (Mont	h, Day, Year)
,	7		20 Normand additions	completed source of de-	th (Item C2=)	Tuna Stict'	Les -	060		Aug	uct z	5,2006
1	LV		30. Name and address of person who called the LEANDER L. MON	CUVL 600	Worth	Wolfe	Smee	+ Baltime	me M	0 2	1287-	9106
	Sta Regist		31. Date filed (Month, Day, Year) AUG 2, 9, 20	32. Segistrar's	Signature	pode	P					to the cause(s) th. Day. Year) 25, 2006

06-06369 Larry Tyler

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		For State	,		Certific	ate of L	Death		F	Reg. No.	200	16 2129
Physician	/ 1	Decedent's Name (First, Middle	e,Last)						2. Date of De Month	Day	Year	3. Time of Death
Medical Examine		Larry Tyler			_	T 40:	07. 7	anting of Do	August 2		ounty of Deat	1628 hrs
	4	a. Facility Name (if not institution 3005 Eastern Avenue	n, give street and i	number)		1	. City, Town, or Lo Baltimore	ocation of Dea	atn	4c. C	ounty of Deat	1
Funeral	5	Social Security Number	6. Sex	7. Age (I	n yrs. last birt		If Under 1 Year	If Under 24h	irs. 8. Date of B	irth(MM/DE		thplace (State or
Director		218-46-7046	1 M 2 F		59	Yrs.	Months Days	Hours M	1in. 04/2	3/194	7 Foreign	North Carolina
any	_	0a. State 10b. County	•	10	c. City, Town	or Location	1					10d. Inside City Limits
nd show	ر ا ج	Maryland N	1/A		Baltim	ore						1 X Yes 2 No
Maryland 28a-f show any d at once.		0e. Street and Number	1/ 22	1_	DOLL CIN		10f. Zip Code			10g. Citizer	n of What Cou	ntry?
ith the Maryland 23a or 28a-f sho notified at once		3005 Eastern A	Avenue				21224			Unite	ed Stat	ces
h with	. I	1. Mantal Status	12. Was D	ecedent Eve Forces?	er in U.S.		Decedent of Hispa , specify Cuban, N					ican Indian, Black,
r deat	5	Never Married 2 Ma	1 X Yes	2		r			,			
rs afte	ଣ⊢	Widowed 4 Div	orced If Yes, Give Y or Dates: cify only highest a	ade comple	-1968 eted) 16a.		Yes 2 No S Usual Occupation		of work done	16b. Kin	d of Business	cican Indian
5-0036 led within 72 hours after death with the Maryland Hygene other than "natural", or items 23a or 28ar fish the Medical Examiner must be notified at one the Andreal Examiner must be notified at one	Completed	Elementary/Secondary (0-12)		(1-4 or 5+)			at of working life. D					·
Edit in the light of the light	Ē	12	1		Ic	nasho	ore man_			Shi	oping 8	Receiving
15-0 Iled w Hygie		7. Father's Name (First, Middle,	Last)			_	18	Mother's Na	me (First, Middle,	Maiden Su	ırname)	-
21215-00 uld be filed wit Mental Hygien marked other c event, the M	8	Roger Tyler 9a. Informant's Name/Relations	hin /Tuno Print \		T <sub>10</sub>	h Mailing /	Address (Street a		Harris	mbar City	as Taura State	7in Cada)
MD 2 ad 2 shoul lith and N m 27 is m aumatic	-71			.la.4	- 1							
	2	Shannon Elligso  Oa. Method of Disposition			20b. Place	of Dispositi	on (Name of ceme	tery,	Date Date	20c. Loc	cation - City or	ore, MD 2120 Town, State
Baltimore, permit Pages I at Department of Hes Important: If ite	- 1	Burial 2 XCremation		from State		ory or othe	•	0.0	2/20/200	6 Da 14	Limoro	Maryland
Baltime permit Pag Department Important: injury or ot	2	Donation 5 Other Sp.  1. Signature of Funeral Service	Licensee /			22. Na	rematory me and Address o	of Facility				
Balt permit Depart Impor injury	1	Sa Part I. Enter the disease, or	A. Wes	201	UFSP	Dav 401	id J. We	eber Fi	neral H	omes l	P.A. re. Mai	wland 21231
Physician	2	3a Part I. Enter the disease, or failure. List only one cause	complications that on each line.	caused the	e death. Do no	ot enter the	mode of dying, so	uch as cardia	c or respiratory a	rrest, shock	, or heart	Approximate Interval Between Onset and
/Medical Examiner		mmediate Cause (Final disease				Cardio	vascular Dise	ase				Death
		r condition resulting in death)	Due to (or as	s a consequ	ence of):							
	<u>اً إِنْ</u>	Sequentially list conditions, fany, leading to immediate	Due to (or as	a consequ	ence of):							
	El (	ause. Enter Underlying Cause Disease or injury that initiated	c. Due to (or as	a consequ	ience of):							1
ecuted and transit		events resulting in death) Last	d.	a consequ	iorioo <b>o</b> i).							
760, cate be execut physician and he burial - tran	/Medical	UNPENDED	AMENDE	)								
760, icate be er physiciar the burial	Me	F FEMALE: 3b. Was decedent pregnant in th			of pregnancy						Date of deliver	•
68° certificanding	lan,	past 12 months?	I L LIVE	e birth gnant at tim			I death 3	_Ectopic preg	gnancy	M	onth	Day Year
Box 687  Re death certifit  the attending  red for use as t	Physician	Yes 2 No 9 Uni	nown H	known	,	J Otne	er (Specify)					
<u> </u>		art II. Other significant condit	ions contributing	to death b	ut not resultin	g in the un	derlying cause giv	en in Part I.	l	-		the cause of death?
S, P.C.	<u>α</u>	*				_			-			bably 4 🗸 Unknown
Division of Vital Records, tal or Attending Physician: The law require is after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director and the funeral di	Completed by								24a. Wa:	psy	prior to	utopsy findings available completion of cause of
Rec The la cate h	E									ormed? 2 No	death? 1 ✔ Y	es 2 No
Vital Respectant: The his certificate director, page	ag 2	5. Was case referred to medica examiner?	Hospital:					of Death (Che		_		
FVi Physical direction	의	1 Yes 2 No		Inpatient		utpatient Time of Inj			sing Home 5		e 6 🗸 Othe	r: Scene
n of hiding Ph.	<u></u>	1 Natural 5 Pend	(Mo	nth, Day,Year		rime or m		es 2 No	200. Describe	s riow injury	occarred	
isior Attend or death. rector: by the	cat	2 Accident Inves	stigation 28e P	ace of Injur	y - At home, fa	arm, street,	factory, office bui	ilding, etc.	28f. Location	(Street and	Number or R	ural Route Number, City
Div ital or iral Di	린		d not be rmined (Speci	fy)				_	or Town,	State)		
Hosp 24 hou Fune		On Contifier	hysician: To the t	est of my k	nowledge, de	ath occurre	ed at the time, date	e and place, a	and due to the cau	use(s) and r	manner as sta	rted.
Divi	Medical		miner: On the bas and manne		nation and/or	investigatio	n, in my opinion, o	death occurre	d at the time, dat	e and place	e, and due to the	ne cause(s)
	Ž	9b. Signature and title of certifie	er 7				29c. License			1		onth, Day,Year)
(*1			emo	)			O.C.M	I.E.		Augus	st 26, 2006	
91	[	<ol> <li>Name and address of person Laron Locke MD A</li> </ol>			'	1 Penn	Street, Baltim	ore MD 2	1201			
				Registrar's		- Fenns	Jucci, Dailim		1201			
Sta Registra	e ar	1. Date filed (Mon Hill )	2006	Pages	K	1	Wi					
DHMH 17 Rev 1/200	01		p <sup>E</sup>	-	OF	RIGINAL						

		Ľ	1 - State Registrar	State of Marylan	d / Depa <i>Cer</i>	artment of F	lealth and Death	Mental Hyg	iene 200 6	27292
	Physici	an	1. Decedent's Name (First, Middle, Last)	naor				2. Date of Dear Month	Day Year	3. Time of Death
	/Medic Examin	al	Cheryl R. U  4a. Facility Name (If not institution, give si			4b. City, Town, o	r Location of Dea	8 ath	25 200 4c. County of De	
	Lxamii		132 2nd St. Red		h	North E			Cecil	
	Funeral Director		918-90-1001	7. Age (In yrs.	ast birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		Year) 9. B	ithplace (State or Foreign Country) Maryland
	uyland show		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo					10d. Inside City Limits
	Ass-f s	ecto	MD Cecil  10e. Street and Number		North	1 East			0g. Citizen of What 0	1 Yes 2000
	3a or	ie Dir	132 2nd St. Red	Point Beac	ch .	21901			USA	outiny :
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural, or iteme 23a or 28a-f show aumatic event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ①Yes 发送No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 Yes 2 No	lispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify:	
20	72 ho 'natur	eted	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup	during most of w	rorking	16b. Kind of Busines	s/Industry
121	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		fice ma			Physica:	l Therapy
nd 2	should be filed vand Mental Hygie marked other turnatic event, III	BeC	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle, I	Maiden Sumame)	
Zla	d Ment market matic	ပို	Vernon Fuller M  19a. Informant's Name/Relationship (Type		10h Mailie	a Address (Street		Hohne	City or Tourn State	Zip Code) 21901
Ma	nd 2 slath an alth an 27 ie r		Dave Unger- hu							n East, MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If Item 27 ie marked any injury or other traumatic ev		20a. Method of Disposition  1 🏞 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State Ga	Place of Dispo	sition (Name of natopy or other plac Of Fai ery			20c.Location-City o Baltimon	r Town, State
Balti	permit. Departnimporte any inju		21. Signature of Funeral Service Dicense		22	. Name and Addre	ss of Facility 3		Dr. For Bel Air	rest Hill, MD 21050
	_		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the death cause on each line.	h. Do not ente	er the mode of dyin	g, such as card	ac or respiratory arri	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Metastat Due to (or as a conseq		Breast	Cano	a ·		0.100.
	Examiner		Securetially list conditions	Due to (or as a conseq	uerice orj.					
	ed isi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uanca of):					
8760,	death certificate be executed a ettending physicien end nd for use as the burial-transit	al Exan	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):					
9	tificate ng phys as the	edical	d.							li
P.O. Box	that the death certified by the ettending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
rds, P	8 P. 8	Ď	Part II. Other significant conditions con	ributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did tot		to the cause of death?  Probably 4 □Unknown
Division of Vital Records,	e law has t	Completed						24a. Was a autops perform	ned? prior to death?	autopsy findings available completion of cause of
/ital		Bec	25. Was case referred to medical examiner?			lo.		eath (Check only on	_	
<del>6</del>	S S D	5	1 Yes 2 No	ospital: 1  Inpatient 2 28a. Date of Injury	ER/Outpatien 28b. Time of		4 🗀 Nursing		ence 6 Other (Sp ow injury occurred	ecify)
ion	Attending in death.	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wor	k?" Yes 2 □No		,	
Divis	tei or Atte s after de ni Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specifi	ome, farm, str	eet, factory, office		28f. Location (St City or Town	reet and Number or I n, State)	Rural Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edicai	29a. Certifier 1 Certifying Phyone 2 Medical Examin	or: On the basis of examina and manner states.	wiedge death tion and/or inv	n occurred at the tir vestigation, in my o	ne, date and pla pinion, death oc	on, and due to the ou curred at the time, d	ausu(s) and markler at a and place, and do	ue to the cause(s)
)	To the within 2: To the I	Σ	29b. Signature and (itt) of certifier	Allfal		29c. Licens	e number 5 65 3		9d. Date signed (Mor	
	12	1	30. Name and address of person who con			Print)				28, 2006
			111 WEST HIGH 31. Date filed (Month, Day, Year)	ST SUI		4 ELL	CTON V	no 210	121	
	Sta Registi		AUG 2 9 2006	1. 400	1 100	West of the second				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2066

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 2102 Monty Hale Vaught 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 10XM 2□ F Yrs. 212-52-6579 Virginia Director June 10, 1949 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or 28a-f show r than "natural, or items 23s or 28s-f shoving Medical Exeminer must be notified at 1 Yes 2 No Directo Maryland Harford Abingdon 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21009 140 Long Meadow Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. ۾ 3 ☐ Widowed 4 ☐ Divorced White eted 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Compl Elementary/Secondary (0-12) College (1-4or 5+) Custodian Public Education ith and Mental Hygie 27 is marked other r traumatic event, il 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Earl Vaught ပ Irene (nmn) Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 1381 Whispering Springs Drive, York, PA 17408 ce of Disposition (Name of Date 20c. Location - City or Town, State Mark A. Vaught / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit, Page Department of Important: If any injury or once. 8-29-06 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Grdns. 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner recettoni Sequentially list conditions, r any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (o: as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Trespiratory Wistress 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? Dortic Value Non ST segment elevations my occidial in 25. Was case referred to medical examiner? 2 No 20 No aretrow 1 ☐ Yes 1 Tyes Be 26. Place of Death | Check only one) Hospital: 1 (46) patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပို 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral L 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Aujust 26 2006 D0053568 Show 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Clear peaks To Bel Air Mary land 5 Jeffrey Thompson MD A 31. Date file Month, Day, Year) State AUG 2 9 2006 Registrar

/avght

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2006 27294 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 08719/2006 2:45 P Vaughn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Cheverly | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O1/15/1915 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖫 F 577-86-2229 91 Franklin, NC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinations. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Prince George's Springdale Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 4015 91st Avenue 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No ff Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lucinda Burt George Alston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosa Mims / Legal Guardian 4433 New Hampshire Ave., NW: Wash., DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 TCremation 3 ☐ Removal from State 08/25/2006 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3831 Georgia Avenue NW Walph Williams Latney's Funeral Home Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Congestive heart Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Seps is attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Demento Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ certificate has been signe rector, page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 2 12 No : After this certifications a funeral director, or Attending Physician: Be 25. Was case referred to medical 26. Pface of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours after To the Funeral Dire To the Hospital 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier The Signature and title of certifier (m) 29c. License number 29d. Date signed (Month, Day, Year) 0005998 August 24, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUKEINE Abdella, MD 3001 Hospital Drive Cheverly, MD 20785 31. Date filed (Month, Day, Year) 32. Reistrar's Signature State Registrar 2006

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene 2006

			1- For State of Maryland / Department Certificat	nt of Health and M te of Death	lental Hygie		27295
-	Physici /Medio Examir	al		Town, or Location of Death	2. Date of Death Month	Day Yeer 5 2006 4c. County of Death	3. Time of Death
	Funeral Director		Baltimore Washington Medical Center  5. Social Security Number  233-68-4152  Usual Residence of Decedent  6. Sex   7. Age (In yrs. last birthday)   If Under Months		8. Date of Birth (Month, Day, Ye Aug. 31, 1	Anne Arui 9. Birthp Cour 943	nde1 blace (State or Foreign ntry) WV
	ne Maryland Ba-f show	Director	10a. State 10b. County 10c. City, Town or Location MD Anne Arundel Pasadena				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	be filed within 72 hours after death with the Maryland hat Hygiene. od other than "natural", or items 23e or 28e-f show event, I'm Medical Evanting must be redified at	uneral Dire	10e. Street and Number   10f. Zip   1246   Silver Run Drive   1. Marital Status   12. Was Decedent Ever in U.S.   13. Was Decedent Ever in U.S.   14. Was Decedent Ever in U.S.   15. Was Decedent Ever in U.S.   17. Was Decedent Ever in U.S.   18. Was Decedent Ever in U.S.   19. Was D	o Code  21122  dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto		U.S.A.  14. Race - Americ Black, White,	can Indian,
21215-0036	in 72 hours af n "natural", or dedical Exam	Completed by Funeral	3 Wildowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usur (Give kind of wo life. DO NOT we have the property of the policy of the pol	al Occupation	ing 16b	Specify: Whi	
	0 = 5	To Be Com	Elementary/Secondary (0-12)  College (1-4or 5+) 4  General 17. Father's Name (First, Middle, Last)  Walter Nathaniel. Whittington	al Manager  18. Mother's Name  Betty Bro	(First, Middle, Maid	Hospitalit de <i>n Sum</i> ame)	<u> Y</u>
Baltimore, Maryland	: 1 and 2 should be Health and Mental tem 27 is marked other traumatic ev	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address	S (Street and Number or Rura ver Run Drive	al Route Number, Ci Pasadena		
Baltimo	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic er once.		4 Donation S Other (Specify)  21. Signature of Finer I Servic, Conjection  22. Name ar		6 Cro		ne, P.A.
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mod shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	to of dying, such as cardiac o	or respiratory errest,		Approximate Interval Between Onset and Death
,8760,	ate be executed hysicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ostoriov N	VI		
P.O. Box 6	at the death certific by the attending p tached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnant at time of death   5   Other (sp			23d. Date of delive Month	ery Day Year
Records, P	w requires thet been signed b should be deta	Completed by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying of Coronary Artery Disease	ause given in Part I.		co use contribute to th	
	rsician: The law s certificate has b lirector, page 2 s	Be Comple	Emoking 25. Was case referred to med 1	26. Place of Death	24a. Was an autopsy performed 1 Yes 2 W	prior to con death?	psy findings available mpletion of cause of
Division of Vital	nding Physic ath. r: After this ce funeral direc	2	examiner?  1		me 5 ☐ Residence 28d. Describe how in	e 6 □Other (Specify njury occurred	")
Divis	i gite	i Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)  29a. Certifier  1 Certifying Physician: To the best of my knowledge. Seeth occurred		City or Town, St		
)	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation and manner stated.  29b. Signature and title of certifier  29c.	, in my opinion, death occurre	ed at the time, date :	and place, and due to  Date signed (Month, i	o the cause(s)  Day, Year)
<u> </u>	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	, SUITE 10		3-25-2 BURNIE	
	Sta Registr		31. Date filed (Month, Day, Pear)  AUG 2 9 2006  32. Beginning	)		M	21001

State of Maryland / Department of Health and Mental Hygien 200627296 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1800 August 2000 Robert Craig Wilkerson, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Hospital Harres Baltimore 8. Date of Birth (Month, Day, Year) 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Davs Hours Months 1**X**M 2□F Director 218-52-3089 56 Jan. 11, 1950 Maryland Usual Residence of Decedent the Maryland 10h. County 10c. City, Town or Location 10d. Inside City Limits 10a State Mode r Items 23a or 28a-f ahor ingraust be natilied at 1 Yes 2 No Director Maryland | Harford Aberdeen 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 1308 Tralee Circle USA 21001 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 Yes 2 No 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No Specify: Specify: Year or Dates: Ď 3 ☐ Widowed 4 ☐ Divorced White "natural" ed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet than Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager Furniture Retail Sales 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be and Mental I Clarence Oliver Wilkerson Lois Rebecca Gilbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen A. Wilkerson/ Wife Health Itam 27 I 1308 Tralee Circle, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If Its any Injury or o ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp | 8-28-06 Towson, Maryland 22. Name and Address of Facility

McComas Funeral Home P. A. 21. Signatur un I Service License 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION HOUR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 Yes certificate 1 ☐ Yes 2 1 No or Attending Physician: 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number
20051865 29b. Signature and the of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUSPITML CHARLES CURTIS mo STAGNOS 32. Registrar's Signatur 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

AUG 2 9 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $2\,0\,0\,6$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August illie **Physician** 2:25 AM 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution give street and number. Examiner Randallstown 9109 Liberty Road Randallstown Baltimore Count If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. 12-17-3 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 225-50-3674 Usual Residence of Decedent 1 □ M 2 SKE Director MIA the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Inportant: If item 27 is marked other then "naturel", or iteme 23e or 28e-1 ehowent injury or other treumatic event, it a Medical Example or injuly be catified at once. 1 Yes 2 No Completed by Funeral Director MD Timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2121 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 31a4 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Essie Ben Brown Jeddinator lla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Baltimore, 20a. Method of Disposition

Burial 2 Cremation on (Name of 06 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Rack Yeur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary Arteru **Physician** DISEASE /Medical Due to (or as a consequence of): Examiner schemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria Be Completed by Physiclan/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Gastrointestina 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has this certificate 1 Yes 2 D M 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Desidence 6 Other (Specify) P 1 Yes 2 N 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? To the Hoepital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 [] Natural 2 [] Accident Injury 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstown -Sa ocelyn 10d 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

AUG 2 9 2006

State of Maryland / Department of Health and Mental Hygien 2006 27298 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Month** Year **Physician** 10:30 2006 HMERICUS /Medical Facility Name (If not institution, give street and number) County of Death 4b. City. Town, or Location of Death Examiner NS9 Home If Under 24 Hrs. Date of Birth (Month, Day, Birtholace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax **Funeral** 1□M 2XF Months Days Hours 79-26-3554 103 Washington DC Director Usual Residence of Decedent with the Maryland 10c. City Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or Itama 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 ☐ No Director Hagerstown Maryland Washington 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21742 U.S.A. 1304 Pennsylvania Ave. death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※No filed within 72 hours after 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event. It s Maralt 2008. (Specify only highest grade completed) National Security College (1-4or 5+) Elementary/Secondary (0-12) Agency Librarian 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Wesley Boteler Daisy Estelle Burrows ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 924 Oak Hill Avenue Hagerstown Maryland 21742 Nancy S. Allen (granddaughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) Aug 17 06 Suitland Maryland Cedar Hill Cemetery 22. Name and Address of Facility Douglas A. Fiery Fuenral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown Maryland 21742 MARIL 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each inc. Approximate nterval Betwee Doset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of Jury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit signed by the attending physician and d be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE.
23b. Was decedent pregnant 12 months? IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 3 Ectopic pregnancy Month Day in the past 12 mon 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ð certificate has been signer rector, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to 26. Place of Death (Check only one) Be examiner' Other: 4 Tursing Home Hospital: 1 ☐ Yes 1 🗌 Inpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? eath After Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accideni 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated the 29c. License number 29b. Signature and title of certifier 3665 (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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ORIGINAL

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y Elizabeth B	•	ON SI 1-For State Registrar	ate of Marylan	o / Departm Certific			and ivie	entair		eg. No. 2	00	5 2	729
Physicia dical Examii	ın/	1. Decedent's Name (First, Middle Mary Elizab		n					Date of Deat     Month     August 9,			Time of De 1343 hrs	
		4a. Facility Name (if not institutio Carroll Hospital Cente	n, give street and num		41	b. City, Town Westmin		on of Dea		4c. County Carroll	of Death		
Funeral Director		5. Social Security Number	6 Sex 7	Age (In yrs. last bi	thday) Yrs.	If Under 1 \ Months   E		Inder 24H ours M	n. B. Date of Bir Decem 12, 1			place (State of	
any	ļ	215-66-9777  Usual Residence of Decedent  10a. State 10b. County		10c. City, Towr		on			12, 1			10d. Inside Ci	ity Limits
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or items	Funeral		arried Armed Ford	dent Ever in U.S. ces? 2 X No	If Ye	es, specify Cu	ban, Mexic	can, Puer	Specify Yes or No to Rican, etc.)	Whit	e, etc.	an Indian, Bla	ack,
11215-0036 Id be filed within 72 hours after fental Hygiene narked other than "natural", event, the Medical Examiner	<u>چ</u>	15 Decedent's Education (Spe			. Decedent	Yes 2 X 's Usual Occu ost of working	pation (G	ive kind o		Specify 16b. Kind of Bu	Whi usiness/In		
1036 sithin 72 Pene	Completed	Elementary/Secondary (0-12)	College (1-2	or 5+)	Home	maker				Own F			
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Thomas Benson						Rutl	ne (First, Middle, Marie) n Boyle				
and 2 should lealth and Mer tem 27 is man traumatic ev	2	19a. Informant's Name/Relations Kathleen Perez			_				r Rural Route Num				1
S 2 = 2		20a. Method of Disposition  1 Burial 2 X Cremation		20b Place crema	of Disposit atory or other	tion (Name of	cemetery	A	Date ugust	20c. Location Frederi	- City or T	own, State	
Baltimore, permit Pages I at Department of Her Important: If ite injury or other tr		4 Denation 5 Other S		11646	22. Na	ame and Add	ress of Fa	cility St	auffer Flvd. Mt.	uneral	Home	s, P.A	
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.									Approximate Between O	e Interval nset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c										
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c	onsequence of):	,							<del>-</del>	
ecuted and transit	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of):									
O, e be exect ysician an burial - tr	edical	UNPENDED	AMENDED							23d. Date o	fdolwood		
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death from the frame of the form of the functal birector. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition.	Physician/Medic	IF FEMALE. 23b Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Un	he 1 Live bir 4 Pregna	nt at time of death	2 Fet	al death ner (Specify)	3 Ect	topic preg	nancy	Month	Da Da	ау 1	Year
r, P.O. B ires that the d signed by the	ρ	Part II. Other significant condi	tions contributing to	death but not resulti	ng in the u	nderlying cau	se given ii	n Part I.		obacco use cont s 2 No 3			
n of Vital Records, ing Physician: The law require After this certificate has been si timeral director, page 2 should b	Completed								24a. Was autop perfo 1 Yes	rmed?		opsy findings impletion of c	
ital Reccionaria The lav	Be C	25. Was case referred to medical examiner?				26 P			ck only one)				
Physic r this	Tol	1 Yes 2 No 27. Manner of Death	Hospital: 1 In 28a. Date o		Outpatient Time of Ir		Other			Residence 6	Other		
Division of Vital ral or Attending Physician: rs after death al Director: After this certicled in by the funeral director	ation:	1 Natural 5 Pen	ding estigation	Day, Year)	. Time of it		Yes 2		200 Beschild	now injury occur			
Division spital or Attentions after death neral Director:	Certification:	3 Suicide 6 Cou	28e. Place (Specify)	of Injury - At home,	farm, stree	et, factory, offi	ce building	g, etc.	28f. Location ( or Town, S	Street and Numb State)	er or Rur	al Route Num	nber, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Directors completely filled in by the	Medical C	29a. Certifier 1 Certifying P	hysician: To the best	examination and/or									
To wit	Mec	29b. Signature and title of pertific	and manner sta	ijea			ense num			29d. Date sign		th, Day, Year)	
20		30. Name and address of person Susan Hogan MD.	n who completed cause Assistant Medica			n Street, E	Baltimor	e, MD 2	21201				

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State Registrar 31. Date filed (Month AUG ear) 5 2006 ORIGINAL

			1 - For State of Maryland / Depa	rtment of Health and M tificate of Death	lental Hygie	ne2006 27300
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	/Medic Examin	al .	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	August 2	5 2006 1:00 A M
	LAdiiiii	CI	22 Middle Street	Taneytown		Carroll County
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Jurie 10,	9. Birthplace (State or Foreign Country) 1927 Maryland
	/land	_	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Loc	ation		10d. Inside City Limits
	e Man ta-f eh	ctor	Maryland Carroll County Taneyton	√n		1 X Yes 2 □ No
	th with th	Funeral Director	10e. Street and Number  22 Middle Street	10f. Zip Code 21787		Citizen of What Country? Lted States
036	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "natural", or iteme 23a or 28a-f ehow event, the Medical Exam her must be notified at	by	Armed Forces? If 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	within 72 ho ene. then "natur he wedical	Completed	(Specify only highest grade completed) (Give life. D	ent's Usual Occupation ind of work done during most of work O NOT use retired)	ing	o. Kind of Business/Industry
	be filed w tal Hygier d other tl	Be Cor	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	
Maryland	should be ind Mental marked o	ToE	Charles Walter Welk		e Lemmon	
Mai	d 2 s th an 7 ls treu			g Address (Street and Number or Run Stone Road West		Maryland 21158
Baltimore,	es 1 an of Heal if Itam 2 r other		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State		Date 200	. Location - City or Town, State
III III	permit. Pages: Department of Inportant: If Its any injury or ot		'4 Donation 5 Other (Specify) MT. Pleas	ant Cemetery	2006 <sup>Ta</sup> iles Fune	neytown, Maryland
Ba	Depa Impo any ir once			6 East Baltimore	Street T	aneytown, Md. 21787
58760, 4	beath certificate be executed attending physicien and for use as the burial-transit	edicai Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ance (no	-Small Cu	Interval Between Onset and Death Onset and Dea
.O. Box 68	0 0	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
<b>Q</b>	9 jo 9	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death? 2 \( \sum No \) 3 \( \subseteq \text{robably} \) 4 \( \subseteq \subseteq \text{Nnown} \)
Records,	0 5 0	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 98 2 No
Vital	Physician: Th this certificate ral director, pag	Be	25 Was case referre medical examiner?  Hospital:	Other	(Check on one)	
o	Phys r this ral di	n; To	27. Many of Death 28a. Date of Injury 28b. Time of	3 DOA 4 Nursing Ho	me Residence 28d. Describe how i	e 6 Other (Specify)  njury occurred
ion	를 등등 글	ation	Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Division	ol or Attend after death Director: J d in by the f	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, streed building, etc. (Specify)	et, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	Hospite 14 hours Funeral tely fille	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invand manner stated.	occurred at the time, date and place, estigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	License number 3	29d.	Data signed (Month, Pay, Year)
	1		30. Name and address person who completed cause of death (Item 23a) (Type, I	Print)		1201000
	3		Yousuf Gaffar, M.D. 5	55 South Center	St. West	minster, Md. 21157
	Sta Registr		31. Date filed (MoAUGY 2°99) 2006 3 Registrar's Signature	ali di		

State of Maryland / Department of Health and Mental Hygien 2006

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	and W		Usual Residence of Decer 10a, State 10b.	County		10c, C	ity. Town or Lo	ocation							10d. Inside City Limits	
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	28a-	Director	Maryland Pr 10e. Street and Number	ince C	eorge'	8	Mitc	helvi	lle Code		-	10	n Citiz	en of What Co	untry?	
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	death me 23	Funerai	10450 Lott	STORG	12. Was Dec	edent Ever in (	J.S. 13.	207 Was Dece	dent of H	ispanic Ori	gin? (Specif	y Yes or No-	1	USA 4. Race - Ame		_
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Baltimore,	그 튼 흔 흔		21. Signature of Funeral				-				200				Virginia	-
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4			23a. Part1. Boter the disc shock, of heart failu	ase, or comp	lications that	aused the dea	ath. Do not en	ter the mod	de of dyin	SITY ng, such as	cardiac or re	espiratory arre	st,	sprin	Approximate	
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	/Medical		disease or condition resulting in death)	-	a	or as a conse	A 40 .	2040	4	400		. ( )			tears	_
	Examiner															
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o.	the de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		9☐ Unkn	nant at time of own	death 5t	Other (s)	овспу)							
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tal	iffication, pe	e C	25. Was case referred to	medical						26 Place	of Doath (	1 ☐ Yes 2 Check only one	No	1 L Yes	2 No	-
5	/sicia s cert direct	To B	examiner?		Hospital: 1 🗅	mpatient 2	] ER/Outpatie	nt 3 De	Oth Oth	0.5				Other (Spe	cify)	
Division of Vital	g Phy er thi	n: T	27. Manner of Death			of Injury th, Day Year)	28b. Time o		28c. Injur Wor			d. Describe ho			negy	-
io	kttendin death. ctor: Afl y the fur	atio	2 Accident	Pending investigation		ur, Day rear)	linjury	М		Yes 2	No					
ivis	l or Atte after de Directo	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	ZNA. Place	of Injury - At I	home, farm, st	reet, factor	y, office		28f	Location (Str City or Town		Number or Ru	ural Route Number,	T
	ital o irs aft ral Di led ir	Cer					,,									
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai	(Uneck only 2 1	ertifying Phi ledical Exam	iner: On the b	asis of examin	nowledge, deat nation and/or in	th occurred ivestigation	at the tir	ne, date an pinion, dea	id place, and ith occurred	due to the ca at the time, da	use(s) a	and manner as place, and due	stated. to the cause(s)	
	the thin 2 the mple	Med	one) 29b. Signature and title of	certifier	and man	neystated.		29	c. Licens	e number	<del></del>		d Date	signed (Mont	h Day Yearl	
	8 4 8 4		leul	4.6	4	Mo	7		72	20	15		8	00		
•	10		30. Name and address of	person who	completed care	se of death (Ite	am 23a) (Tune	Print)			,		- (	1	. 1	-
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		4	For State Registrar		St	ate of M	laryla	nd / Depa <i>Cei</i>	artme <i>tifica</i>	ent of H ate of L	ealth a D <i>eath</i>	and M	ental Hy	gien Reg. N		06	273	02
Ī	Physicia /Medic		1. Decedent's Nam		lyle	c.	Cra	ig					2. Date of De Month Aug.	9 ,	<sup>ay</sup> 2006	Year	3. Time of E	
-	Examin	_		Cross	Hosp	pital			Si	y, Town, or Lver		ing	C Data at Ri	4	c. County o	of Death		Caraina
	Funeral Director		5. Social Security N 299-12- Usual Residence of	-1818	6. Sex 1 <b>⊠</b> M	,	80	i. last birthday) Yrs.		s Days	Hours	Min.	8. Date of Bir (Month, Da 2-1-	26	r)	Or	place (State or htry)	roreign
	Maryland f ehow	lor	10a. State  MD.	10b. County	gomei	сy		Silver		ring							0d. Inside City	
	with the Page or 28a-	Funeral Director	10e. Street and Nu	Motre	Dame	Lane	2		10f. 2	Zip Code 2090	6			10g. C	U.S.		ntry?	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23s or 28s-f show any Injury or other traumatic event, It a Medical Examinat must be notified at once.	by Funera	11. Marital Status	ried 2 <b>√∑</b> Marr	12. V	Vas Deceden Armed Forces Yes 2 (f Yes, Give Year or Dates	nt Ever in s? ]No			cedent of Hi becify Cuba 2 No	spanic Ori n, Mexicai Specify:	igin? (Spe n, Puerto I	cify Yes or No Rican, etc.)	)-		, White,	_	
21215-0036	within 72 hou ane. then "natura he Medical E	Completed	(Spe	15. Decedent cify only highes ondary (0-12)	t grade cor	on mpleted) College (1-40	r 5+)	(Give	kind of 1 DO NOT	sual Occupa work done of use retired	luring mos ) 			16b.	Kind of Bus	siness/Ir	dustry	
Maryland 2	ld be filed view lental Hygie ked other ic	To Be Co	17. Father's Name	(First, Middle,							18. Moth	er's Name	(First, Middle Reed	, Maide	an Sumame	9)		
	nd 2 shou alth and N 27 is mar ir traumat		19a. Informant's N	D. Cr					•				ie, S.	-				
altimore,	Pages 1 anneal of Heanneal of			sposition Cremation 5 □ Other (S		oval from Stat		Place of Dispo cometery, crer ate of					ate 5/06		Location - (		own, State oring,	Md.
Balt	permit. Page Department of Importent: If any Injury or ance.		21. Signatura of F	uneral Service	Licensed D. Ho	ckus	Ar.	22	Hac B14	and Address kett Ups	s of Facili S F hur	une: Stre	ral Ch	ape	el, ]	[nc.		
8760,	Physician and // / / / / / / / / / / / / / / / / /	dicai Examiner	Immediate Cause disease or condition resulting in death)  S. uentially list continue if any, leading to it cause. Enter Und Cause (Disease of that initiated event resulting in death)	onditions mmediate erlying erlying	a b c d	Infe	cted	equence of):  Left  equence of):  equence of):	Foo	ot Wo	und	and	Gangı	rene	е		Onset and D	Balli
P.O. Box 68	law requires that the death certific as bein signed by the attending pl 2 should be detached for use as t	by Physician/Med	IF FEMALE: 23b. Was decede in the past 1: 1 □ Yes 2 9 □ Unknow	2 months?		if yes, outcorr 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Fe at time of	tal death 3		pregnancy (specify)					23d. Date Mon			9ar
	w requires that the base of the control of the detact should be detacted to the detacted the control of the con		Part II. Other sign	ificant condition		_	but not re	esulting in the u	nderlyin	g cause give	en in Part	l.					he cause of de	
Vital Records,	: The law recate has be	Completed											24a. Was auto perf 1 \( \text{Yes}		' d	eath?	opsy findings a empletion of ca 2 \( \text{No} \)	vailable use of
<u> </u>	Physician: r this certific ral director,	To Be	25. Was case reference examiner? 1 Yes 2		Hosp	ital:	itient 2	☐ ER/Outpatier	nt 3 🗆	DOA Othe			Check only me 5 ☐ Res		6 □Othe	ır (Speci	fv)	-
Division of	spitei or Attending Physician: The lav ours efter death. neral Director: After this certificate has filled in by the funeral director, page 2		27. Manner of Dea	th 5 🗌 Pendir investi	gation	8a. Date of Ir		28b. Time o Injury	_	28c. Injun Worl	/ at <br Yes 2 □	2	28d. Describe				,,	
Divis	tel or Atters of setter de al Directo ed in by the	Certification;	3 Suicide 4 Homicide	6 Could determ		8e. Place of building,	Injury - At etc. <i>(Spe</i>	home, farm, str cify)	reet, fact	tory, office		2	28f. Location City or To			r or Rur	al Route Numb	19 <i>r</i> ,
	To the Hospitel within 24 hours e To the Funeral C completely filled	ledical	29a. Certifier (Check only one)	2 Medical	Examiner:	m: To the be On the basis and manner	of exami	nowledge, deat nation and/or in	vestigati	ion, in my o	pinion, dea	nd place, a ath occurre	and due to the	date a	nd place, a	nd due I	o the cause(s)	
)		Σ	29b. Signature an	· Mys	019/	M	8.			D006		)			8/09		Day, Year)	
1	++1		30. Name and add	usonge	Mo compl	ted cause o	f death (It 01 F	orest	Print) Glei	n Rd.	s.s	5. Mo	d. 209	10				
	Sta Regist		31. Date filed (Mo	AUG 1		32. Rogi:	strar's Sig	nature	base	e de								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-c, 10e-f, per Inf G883 9/22/08 TT
State of Maryland / Department of Health and Mental Hygien?

722708 TT Department of Health and Mental Hygien 2006 27303 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Celestine Beste Converse August 9, рм 2006 1:20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 10019 Brunett Avenue Montgomery

9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X** F 468-34-2994 Director 79 Yrs. March 9, Minnesota 1927 Usual Residence of Decedent with the Maryland 10b. County State 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or iteme 23a or 28a-1 show ury or other traumatic event, the Madical Expression that be notified at Daytona Beach Shores Volusia Florida 1 ☐ Yes 2X No Director Maryland Montgomery Spring 2545 S. Atlantic Ave., 10g. Citizen of What Country? 10f 32 f 18 #603 10019 Brunett Avenue 20901 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify White 1 Yes 2 No Specify: Completed by 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew Beste Helen Quirk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10019 Brunett Avenue, Silver Spring, MD 20901

e of Disposition (Name of Date 20c. Location - City or Town, State Cahil A. Converse/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: if ite any injury or of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State August 16, St. William Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Ware, Massachusetts 21. Signature of Funeral Service Licensee 22. Name and Address of Faculty. Francis J. Collins Funeral Home Inc. ). De 500 University Blvd, W, Silver Spring, MD 20901 esus 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Jejunal Carcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to minisolate cause. Enter Underlying Cause (Disease or injury Dire to (or as a consequence of) Examine law requires that the death certificate be executed burial-transit that initiated events physicien and resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 🕅 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performad/ The certificate 21 110 2 No 1 ☐ Yes of Vital Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation in 24 hours efter deat. he Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier with in 24 hor To he Fune completely fi (Check only one) 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51916 August 10, Ville Pike, G-120, Row Kville latucia nag 30, Name and address of person who completed—use of death (Item 23a) (Type, Print) 10 Tricia dy 31. Date filed (Month, Day, Year)
AUG 1 4 2006 32. Agistrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1- State of Maryland / Department / Department / Departmen	artment of Health and N Tificate of Death		ene <b>2 U U 6</b>	2/304
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
H	/Media	cal	Ettie L. Champion  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		11, 2006 4c. County of Death	4:51 A <sup>M</sup>
	Examir	ner	Southern Maryland Hospital	Clinton		P.G.	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2X F 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y 3-29-2	rear) Cou	place (State or Foreign intry)
	and		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo	cation			10d. Inside City Limits
	Mary a-f sho	tor	MD. P.G. Templ	e Hills			1 ☑ Yes 2 ☐ No
	or 28	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cou	intry?
	ns 23s	Funeral	5711 - Hartwell Street  11. Marital Status 12. Was Decedent Ever in U.S. 13. V	20748 Was Decedent of Hispanic Origin? (Sr	pacify Yes or No-	U.S.A.	ican Indian
5-0036	n 72 hours after death with the Maryland "netural", or items 23s or 28s-f show police! Exertiret must be notified at	þ	1 Never Married 2 Married 1 Yes 2 TNo	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto I ☐ Yes 2 <b>XX</b> 00 Specify:	Rican, etc.)	Black, White	, etc.
<u>ν</u>	72	leted	15. Decedent's Education (Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of work DO NOT use retired)	king 16	6b. Kind of Business/Ir	ndustry
717	d within giene. r than	Completed	Elementary/Secondary (U-12)   College (1-4or 5+)	Domestic			
פ	be filed ital Hygi id other event, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma	aiden Sumame)	
Maryland	d Men marke	၉	Columbus Gaither  19a. Informant's Name/Relationship (Type, Print)  19b. Mailin	Luever and Number or Rur	enur Gat		- 0- 4-1
	alth an 27 is i			Hartwell St.			
Baltimore,	of He and of the and o		20a Method of Disposition 20b, Place of Dispo	sition (Name of natory or other place)	Date 20	c. Location - City or T	
<u>=</u>	it. Pag ntment njury o		4 ☐ Donation 5 ☐ Other (Specify) Harmony			Landover,	
n Pa	permit. Pages 1 and 2 should by Depertment of Health and Menta Important: if item 27 is marked eny injury or other traumatic es		forme Callenie	Name and Address of Facility. The House of W: 814- Upshur St:	reet, N.	W	
	Dhusisian		23a. Part. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest	t.	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a.   Deat to (or as a consequence of):	eed			
	Examiner	_	Sequentially list conditions b. Cardio senic	Shock			
	uted I Insit	mlne	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	HD			
Ď	ficate be executed physicien and is the burial-transit	Examin	that initiated events resulting in death) Last Due to (or as a consequence of):				
98/90	cate be	edical	d. Anelina				
e XOE		n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	Arv
ğ 	requires that the death certil seen signed by the ettending hould be detached for use e	Physician/M	in the past 12 months?	Ectopic pregnancy Other (specify)		Month	Day Year
as, r	uires tha signed Id be del	Ď	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I.		cco use contribute to t	
ecords,	aw as b	Completed			24a. Was an autopsy	24b. Were auto	opsy findings available impletion of cause of
<u> </u>	pa es				performe	d? death?	2 No
<u> </u>	Physician: rthis certific ral director,	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No  Hospital: 1 Inpatient 2 □ ER/Outpatient	Othor	h Check only one	ce 6 □Other (Specif	6v)
0	ng Ph tter th	on; T	27. Manyer of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year) 28b. Time of Injury		28d. Describe how		7)
VISION	death.	ertification;	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f Location /Street	et and Number or Rura	al Pauta Number
2	s effer s effer al Dire ed in b	Certi	4 Homicide determined building, etc. (Specify)	ist, factory, office	City or Town, S	State)	ar noble ryumber,
	To the Hospitel or Attending within 24 hours efter death.  To the Funers! Director: After completely filled in by the fune.	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as s a and place, and due to	o the cause(s)
	To with To t	Σ	29b. Signature and the of certifier	29c. License number	29d	. Date signed (Month,	
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, It	D0053219	8	[ 11 2001	0
-			Zafar Ansari, M.D. 2849 Duke St	Alex. Va. 2	2314		
	Sta Registr		31. Date filed (Monte, Day, Year)  AUG 1 4 2006  32. Registrar's Signature	uli			

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006

			For State of Maryland / Department of Health and Me State Registrer Certificate of Death	ental mygle Reg.		21305
	Physici	an.	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Mary Katherine Curry	August 1	3 2006	5:00 AM
ř	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Deat	h
Н	Funeral		360 Buena Vista Ave Hagerstown  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	<ol><li>Date of Birth</li></ol>	Washingto	on County  hplace (State or Foreign untry)
	Director		217-56-1627 1 M 2XIF 57 Yrs. Months Days Hours Min.	(Month, Day, Ye	2 1949 Mar	
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	THOSE CIT 12	- 1747 PIGI	10d. Inside City Limits
	Aaryla Fehor	ō				1X Yes 2 No
	28a-	rect	Maryland Washington Hagerstown  10e. Street and Number 10f. Zip Code	10a.	Citizen of What Co	
	death with the Maryland oms 23a or 28a-f ehow if must be notified at	Ö	360 Buena Vista Ave 21740			,
	ems :	ner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Plants)	cify Yes or No-	14. Race - Ame Black, White	
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Department if them 27 is marked other than "naturel; or items 23a or 28a-f show eny injury or other traumetic event, the Madical Examinar must be notified at once.	by Funeral Director	1 Never Married 2 Married 1	iouri, etc./	Specify: Wh	
ဂ ဂ	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of workin	a 16t	o. Kind of Business/	Industry
7	within ane. than '	du	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)			
2	filed Hygie Sther	ပိ	11. Homemaker  17. Father's Name (First, Middle, Last)  18. Mother's Name		Personal	Residence
yland	lid be fental rked c	To Be		ouise Zi		
Mary	should have		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural			lip Code)
e,	ss 1 and 2 of Heelth of Item 27 I	ļ	Richard E. Curry Sr. (husband) 209 Alexander St. Ha 20a. Method of Disposition (Name of Dispo	gerstam	Maryland	21740
0	ges 1 If of H or oth		X Burial 2 Cremation 3 Removal from State			200
Baltimoi	it. Pa iritmer iritmer iritmit:				agerstown	
g	Depa Impo	1	Junto A. Tury 1331 Eastern Blvd.	N. Hager	Fiery Fun stown Mar	eral Home yland 21742
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart fadure. List only one cause on each line.	respiratory arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Fiñal disease or condition resulting in death)  a. JSChemic Meast acid	ease		Onset and Death
	Examiner		Due to (or as a consequence of):			
		Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	tificate be executed g physicien and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
Š	oe exe cien a urial-l	EX	resulting in death) Last Due to (or as a consequence of):			
08/00,	cate t physic the b	edical	d			
D X O	certific nding p		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		22d Date of deli	
<u>n</u>	law requires that the death cer es been signed by the attendin 2 should be detached for use	Physician/N	in the past 12 months?  1		23d. Date of deli Month	Day Year
5	by the	hys	9 ☐ Unknown 9 ☐ Unknown			
'n	res that igned be de	<u>م</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		co use contribute to	
cora	requi	eted	19708 in idemia	1 Yes		obably 4 DUnknown
S L	The law requires that ste hes been signed b page 2 should be deta	Completed	Hyper tewns	24a. Was an autopsy performed	24b. Were au prior to death?	topsy findings available completion of cause of
		0	25. Was case referred to medical 26. Place of Death	1 ☐ Yes 2 ☐	No 1 ☐ Yes	2 □ No
> =	Physical this cer al direc	To B	examiner?		e 6 □Other (Spec	cify)
	Ing I	ë.	1 Natural 5 Pending (Month, Day Year) Injury Work?	8d. Describe how i	njury occurred	
2	l or Attendi efter death Director: A I in by the fu	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28e.	Of Location (Chan-	4 a a of \$1, and a constant	-18
2	efter efter Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, S	t and Number or Ru tate)	rai Houte Number,
	To the Hospital or Attentwithin 24 hours effer deatl To the Funaral Director: completely filled in by the		29a. Certiflier  (Check only  2   Medical Examiner: On the basis of examination and/or investigation in my onining death occurred.	nd due to the caus	e(s) and manner as	stated.
	the H hin 24 the F nplete	Medical	one) and manner stated.			
	5 × 5 × 5		29b. Signature and title of celtifier 29c. Lichase number 29c. Lichase number 29c.	29d.	Date signed (Month	Day, Year)
			30. Name and address of person who completed cause of death (Items 23a) (Type, Print)	1 . /.	7/1/	11
ک	H-3		J. Hencherry MD. 1282/ Oak	hill	avre,	Hagerstan
	Sta	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature		/	MOD1742
	Registr	ar	AUG 1 6 2006 Leven S. Specker			

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland	Department of Healt Certificate of Dea	th and Mental Hygie		27306		
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last)  CHARLES	DELBERT	COOPER	2. Date of Death Month August	14 2006	3. Time of Death 3.35 P M		
	Examir Funeral Director	ier	4a. Facility Name (If not institution, give str.  VDS HING W  5. Social Security Number 6. Sex  705-12-5910	1 11	birthday) If Under 1 Year If Under 1 Year Months Days Hou	ndef 24 Hrs. 8. Date of Birth (Month, Day, Ye	4c. County of Death WISHINSTON  9. Birthplac Country  1912 MAR	ce (State or Foreign		
		7.	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location	JULY 21,		YLAND  I. Inside City Limits		
	with the M la or 28a-f Le rollli	Director	MARYLAND WASHIN  10e. Street and Number  11121 LAKESIDE DRIV		HAGERS 1 10f. Zip Code 21740	10g.	. Citizen of What Country	,		
336	72 hours after death with the Maryland naturel', or itema 23a or 28a-1 ehow disal Examinar musi be rodilled at	by Funeral		. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2X No Spec	c Origin? (Specify Yes or No- kican, Puerto Rican, etc.)	U.S.A  14. Race - American Black, White, etc.  Specify:	n Indian,		
Maryland 21215-0036	within ane. than "	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion 16 completed) College (1-4or 5+)	Give kind of work done during r life. DO NOT use retired)  CARMAN	most of working	16b. Kind of Business/Industry			
yland;	should be filed nd Mental Hygir marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) DENNIS R. COOPER		18. M	lother's Name (First, Middle, Mail	iden Sumame)			
	1 and 2 Heelth a em 27 is		19a. Informant's Name/Relationship (Type NANCY G. MOHLER, DA 20a. Method of Disposition	UGHTER 20b. Place	19b. Mailing Address (Street and Nun 2483 FIVE SHILLI a of Disposition (Name of stery, crematory or other place)	INGS ROAD, FRED		LAND 21701		
Baltimore,	permit. Pages Depertment of Important: If it eny injury or o		1 Surial 2 Cremation 3 Ren 4 Donation 5 Other (Specify) 21. Signatu e of Fun ral Service Licensee	IUVAI IIUIII SIAIB	N HILL CEMETERY  22. Name and Address of Fa	acility 7606 OLD I	AYNESBORO, NATIONAL PI	KE		
	Physician /Medical Examiner	_	23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	tions that caused the death. Dicause on each line.  Hypoxia  Due to (or as a consequence)	ce of):	BUUNSBURU	, A	21713 pproximate nterval Between onset and Death		
8760,	cate be executed physicien and the burial-transit	dicai Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence						
.O. Box 6	that the death certific ed by tha attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown			23d. Date of delivery Month Da	ay Year		
ords, P.	w requires that the been signed by the should be detached		Part II. Other significant conditions contril	Boe Jins	g in the underlying cause given in Pa	art I. 23e. Did tobacc	co use contribute to the o	12		
Vital Records,	The law ate has b page 2 si	e Completed by	CHICANIC KIDNER DISPHAGIO ON 25. Was case referred to medical	1 NO PC	) intote	24a, Was an autopsy performed	death?	y findings available letion of cause of No		
ot	or Attending Ph ter death. Irector: After th by the funeral	Certification: To B	examiner?  1 Yes 2 No Hos  27. Nanner of Death LA Natural 5 Pending 2 Accident investigation	-	Outpatient 3 DOA Other: 4 Do. Time of Injury M 28c. Injury at Work?  M 1 Yes 2		njury occurred t and Number or Rural R	oute Number,		
_	To the Hospital of within 24 hours of To the Funeral Documental Documents of Total o	edical	29a. Certifier (Check only one)  Certifying Physici  Check only 2 Medical Examiner	an: To the best of my knowled On the basis of examination a and manner stated.	ige, death occurred at the time, data and/or investigation, in my opinion, o	and place and due to the cause death occurred at the time, date	a(s) and marmar as statu and place, and due to th	id. e cause(s)		
)	To t To t	Σ	29b. Signature and title of certifier	van Mi	29c. License number	er 29d. 1	Date signed (Month, Pay	v. Year)		
اف	H-7 Sta	te	30. Name and address of person who compared to the second	oleted cause of death (Item 23a	a) (T pe, Print)	r st. Hages	Eny, NOS	1900		
	Registr		AUG 1 6 200		Spell					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 For Amend #8 Per FH Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 4:45 PM AUGUST 2006 13 DAWN MARIE DENNY /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner OUEEN ANNE'S STEVENSVILLE 305 RIVER SHORE LANE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 1968 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax **Funeral** 1 ☐ M 2 💢 F 06/10/2006MD 38 Director 216-86-1543 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or 28a-f show in than "natural", or items 23a or 28a-1 show the Wedical Examiner must be notified at 1 ☐ Yes 2 No Director QUEEN ANNE'S STEVENSVILLE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21666 USA 305 RIVER SHORE LANE death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify. Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wire Department of Health and Mental Hygien. Importent: If item 27 Is marked other than any Injury or other traumatic event, Italy 2008. 4 FINANCIAL ASSISTANT ANNE ARUNDEL MEDICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RHEA WALDEN ROBERT F. SHORT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 305 RIVER SHORE LANE, STEVENSVILLE, MD 21666 RICHARD CARVEIL DENNY / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 08/16/2006 STEVENSVILLE, MD \* 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK RD., CHESTER, MD 21619 caused the death. Approximate 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Wes decedent pregnant 2 Fetel death 3 Ectopic pregnancy for Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ed bluods 3 ☐ Probably 4 ☐ Unknown 2 FINO 1 TYPS Completed been 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performed 2 🗆 No 2 10 1 Yes 1 Yes Phyeician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 2 No 5 Residence 6 Other (Specify) 2 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending Natural 5 Pending investigation death. M 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Unv. of

State Registrar

Lathenne 31. Date liled (Month, Day, Year)

AUG 15

32. Registrar's Signature

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Registrar Certificate of Death		Reg No	2006	2730
Physicia ledical Exami		1. Decedent's Name (First, Middle,Last)  Anthony Louis Difilippo Sr.	Mont	of Death h Day J <b>st</b> 20, 2006	Year 3.	Time of Death  2300 hrs
Killy,		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location			ounty of Death	
, i		Peninsula Regional Medical Center Salisbury		Wic	comico	
Funeral				e of Birth (MM/DD	/YYYY) 9. Birthpl Foreign	ace (State or
Director		264-45-5871 1 X M 2 F 46 Yrs. Months Days Hot	ours Min. 10/	19/1959	Countr	<sup>y)</sup> Delaware
ķ		Usual Residence of Decedent  10a State 10b. County 10c. City, Town or Location			110	d Inside City Limits
ow any						X Yes 2 No
rylancia-fia-fish	턍	Maryland Wicomico Salisbury  10e Street and Number 10f, Zip Code		10g Citizen	of What Country	
he Ma	Director	611 Jefferson Street 21804		USA		
with with Star Pe not		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic C			Race - American	Indian, Black,
death or iter	Funeral	1 Never Married 2 Married Armed Forces? 1978 If Yes, specify Cuban, Mexic		rtc.)	White, etc.	
215-0036 be filed within 72 hours after death with the Maryland mal Hygiewith ham "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	ģ	3 Widowed 4 X Divorced If Yes, Give Year 1982 1 Yes 2 X No specify on Dates:  15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Given Section 15)			ecify: Whi	
2 hour "natu	ted	15 Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)		e Tob Kind	of Business/Indu	stry
336 thin 7. re. than edical	Completed	12 Drywall Installer	r	Con	structio	n
5-0036 iled within 77 Hygiene. I other than	S		ther's Name (First, N	liddle, Maiden Sui	rname)	
21215-003 buld be filed withi Mental Hygiene, marked other the	Be		nabelle V			2 11
sho and and 7 is	ဠ	19a. Informant's Name/Relationship (Type, Print)  Anthony L. DiFilippo, Jr./Son  6545 Morris Roa				Code)
- p = g = l		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,			ation - City or Tov	vn, State
<u> </u>	П	1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify MD Veterans Cemetery	8/25/20	06 8011	ah, Mary	1 and
Baltimor pernit. Pages Department of Important: If		21. Signatury of Funeral Service Const. / / 22. Name and Address of Fac	cility	*		Tand
Per De	1	Zeller Funeral 1212 Old Ocean	l Home, P n City Ro	. O. Box ad, Sali	31/1 sbury, M	D 21802
Physician /Medical	Ч	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a failure. List only one cause on each line.	as cardiac or respira	tory arrest, shock,		pproximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  Fentanyl intoxication  Due to (or as a consequence of):				Death
pa		Sequentially list conditions,  b				
	ner	if any, leading to immediate Due to (or as a consequence of):				
	Examiner	C. Due to (or as a consequence of):				
scuted and transi		d				
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	≥ 1	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Fetal	topic pregnancy	23d D	ate of delivery	Year
Box 687: death certifine the attending as the fortuse as the second to t	sician	4 Pregnant at time of death 5 Other (Specify)				,
Bo he dear the a	Phys	1 Yes 2 No 9 Unknown 9 Unknown	Dord L	Didtabases		
P.O.	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Dilated cardiomegaly	1 Part I.	Did tobacco use		y 4 V Unknown
rds, requires been sig	ted	Direct cartifologis	248			sy findings available
Records, The law require ficate has been si	Completed			autopsy performed?	death?	pletion of cause of
tal Rec tian: The l certificate l		25. Was case referred to medical 26.Place of Dea	ath (Check only one	Yes 2 No	1 🗸 Yes	2 No
of Vital  ng Physician:  of the certi-  of the cert	o Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA  Other4			e 6 Other:	
of ing Phy After t	n: To	27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at W	Vork? 28d. De	escribe how injury	occurred	
ion trendi leath. tor: /	atio	Natural 5 Pending Fnd 8/20/2006 Fnd 10:14 pm 1 Yes 2	□X № un	k		
Division tall or Attending as after death.  The all Director: A led in by the fu	Certification	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building.		cation (Street and Town, State), Rt	Number or Rural I	Route Number, City ella St.
Dispital hours a meral I		4 Homicide determined (Specify) found in automobile		rown, State). Rt sbury, MD		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death				use(s)
To To	Mec	and manner stated.  29b Signature and title of certifier / 29c. License numb	ber	29d. Dat	e signed (Month,	Day, Year)
		Carol Hallon O.C.M.E.		Augus	t 21, 2006	
		30. Name and address of person who completed cause of death (Item 23a)				
		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, M	MD 21201			
S Regis	tate trar	31. Date filed (Month, Day Year) 4 2006 32. Figistrar's Signature				
Kegis	uell	NAME OF THE PARTY				

State of Maryland / Department of Health and Mental Hygiene 2006 For State Registres Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** William B. Eldridge August 05, 2006 5:16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery | Betnesda | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | Jan. 26,1931 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F Yrs. 75 Director 520-34-1423 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County al Hygiene. I other then "neturel", or itema 23a or 28a-f ehov vent, the Medical Examinat must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11209 Old Post Road 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 🖄 Yes 2 □ No If Yes, Give Year or Dates: 56-60 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Lawyer Legal permit. Pages 1 and 2 should be filed Deperment of Health and Mental Hyg Important: if item 27 is marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James E. Eldridge Clara Mae Butler ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Eldridge / Spouse 11209 Old Post Road; Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 8/11/2006 Brentwood, Maryland 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 21. Signature of Funeral Service Licensee 1040 kockville Pike; Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final PULMONARY EMBOLIS **Physician** disease or condition resulting in death) /Medical Examiner CARDWARY ARTERY DISBASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month · Year 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ TITK nown MBLLITUS Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death Check only one examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient Certification: To 3 DOA this After this funeral d 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely tilled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ruchan BROALBULY PAYSILIAN 12+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALCONTH MD 80
Year) 32. Pegistrar's Signature 3600 OLD GEDRLEKEN RP. RICHARD 31. Date filed (Month, Day Year) AUG 1 4 Registrar Marke

			For Stete Registrar	State of	Maryland / Dep	ertificate of D	eath		en <b>2</b> 006	27311
	Physici		Decedent's Name (First, Midd     TKEST_HARRISO	(16, Last) N EKPESOMHEGBE	7			2. Date of Death Month AUGUST	Day Year	3. Time of Death 3:10 AM
	/Medic Examin		4a. Facility Name (If not institution			4b. City, Town, or Lo	ocation of Death	NOCODE	4c. County of Dea	
	Exami	Ü.	HOLY CROSS H	OSPITAL		SILVE	R SPRING		MONTGOMERY	ď
	Funeral Director		5. Social Security Number NONE	6. Sex 7. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Age (In yrs. last birthda Yrs.	) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JULY 24,	Year) 9. 8ii 2006 MA	rthplace (State or Foreign ountry) ARYLAND
	pur *	}	Usual Residence of Decedent  10a. State 10b. Count	· · · · · · · · · · · · · · · · · · ·	10c. City, Town or	coation				10d. Inside City Limits
	sho	5								1 ☐ Yes 2 ☑ No
	the N	Director	MARYLAND MONTGO  10e. Street and Number	MERY		SILVER SPRING		10	g. Citizen of What C	
	a or	ā						10		
	eath	era	#6 WAGON TRAIL	12. Was Decede	ent Ever in U.S. 13	20906 Was Decedent of History	anic Origin? (Spe	city Yes or No-	U.S.A. 14. Race - Am	
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. ad other then "neturel", or flems 23a or 28a-f show event, I're Medical Exercifier roust be notified at	by Funerai	1 ☑ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1 Tyes 2	No	. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No	Mexican, Puerto I	Rican, etc.)	Black, Whi	
Ģ	2 hou	ted	15. Decede	nt's Education	16a. Dec	edent's Usual Occupation	on	1	6b. Kind of Business	
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21	d with	E	0	College (1-4	01 34)	NONE			NONE	
פ	2 should be filed withir and Mental Hygiene. is marked other then eumatic event, Ire M.	Bec	17. Father's Name (First, Middle	, Last)		1	8. Mother's Name	(First, Middle, M	laiden Sumame)	
Maryland	should be fand Mental I s marked of umatic eve	2	FESTUS EKPE	SOMHEGBE			LANGO	TUCKER		
ar	2 sho and h is ma		19a. Informant's Name/Relation	ship (Type, Print)	19b. Ma	iling Address (Street and	d Number or Rura	l Route Number,	City or Town, State,	Zip Code)
	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		LANGO T. EKPESOMH	EGBE - MOTHER		AGON TRAIL COU		R SPRING.	MARYLAND 209	906
ore	iges 1 it of He if item or oth		20a. Method of Disposition 1   Burial 2 □ Cremation	3 Demoval from St	20b. Place of Dis	oosition (Name of ematory or other place)	D	ate 2	Oc. Location - City of	r Town, State
Ĕ	nit. Pages sartment of lordent: If its injury or o	/	`4 □Donation 5 □ Other (			AVEN CEMETERY	AUGUST	18,2006	SILVER SPRIN	G. MARYLAND
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr		21. Signature of Funeral Service	Licensee		22. Name and Address				CONTRACTOR CONTRACTOR
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cau	sed the death. Do not e	nter the mode of dying,	such as cardiac o	r respiratory arre	st,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. TRISON	ſY 13					SINCE BIRTH (15 DAYS)
	Examiner				as a consequence of):					15 DAYS
		er	Sequentially list conditions, if any, leading to immediate	U	E HYPOXIA as a consequence oi).					15 DATE
	uted d ansit	E L	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	RESPIE	RATORY FAILURE					
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.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 Fetel death 3 nt at time of death 5	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	olivery Day Year
Δ.	res that the de igned by the a be detached t	by Ph	Part II. Other significant condit	ions contributing to deat	th but not resulting in the	underlying cause given	in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
Ž	w requir been si should	ted						1 🗆 Yes	s 2 🖾 No 3 🗌 P	robably 4 Unknown
Records,	ystcien: The law r is certificate has be director, page 2 sh	Completed	1					24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of s 2 \( \sum \) No
Vital	u <b>cien</b> : Th certificate rector, pag	Be	25. Was case referred to medical examiner?	al		2	26. Place of Death			
of <	Physicien: this certific ral director,	2	1 Yes 2 No	Hospital: 1 X Inp	atient 2 ER/Outpati	ent 3 DOA Other:	4 🗌 Nursing Hon	ne 5 🗆 Resider	nce 6 Other (Spe	ecify)
	Jing After fune		27. Manner of Death  1 Natural 5 Pend 2 Accident invest	28a. Date of (Month, tigation	Injury 28b. Time Day Year) Injury	Work?		8d. Describe hov	w injury occurred	
Division	ei or Atte s after de il Directo	Certification;	3 Suicide 6 Could 4 Homicide deten	mined 286. Place of	Injury - At home, farm, s , etc. <i>(Specify)</i>	street, factory, office	2	8f. Location (Stre City or Town,	eet and Number or R State)	tural Route Number,
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physicien: To the basi I Examiner: On the basi and manner	is of examination and/or	ath occurred at the time, investigation, in my opin	, date and place, a lion, death occurre	and due to the car ed at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifi	er		29c. License n	number	29	d. Date signed (Mon	th. Day, Year)
			<b>T</b> /1	(3/4/2 - 1	MO	D641	68		8/7/	06
	1		30. Name and address of person	who completed cause	of death (Item 23a) (Type			l	3/-/	
_			JOHN ROUHANI, M.I	., 1500 FORES	r GLEN ROAD, S	ILVER SPRING.	MARYLAND 2	20910		
	Sta		31. Date filed (Month, Day, Year	) 32 Reg	istrar's Signature	_				
	Registi	ar	AUG 1	4 2006   1	aca B. B.	panel				

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** FRIEDMAN 11:15 A M August 11, 2006 Herman Meyer /Medical 4c. County of Death Montgomery 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Shady Grove Adventist Hospital 7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. March 14, 1 Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 11€ M 2□ F New York 1920 120-12-5674 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show items 23a or 28a-f shov 1 ⊈Yes 2 No Rockville Director MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20850 104 531 Lawson Way Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Armed Forces?
1 X Yes 2 □ No
If Yes, Give 7: filed within 72 hours after 1 Never Married 2 Married White 2 If Yes, Give WWII 1 ☐ Yes 21 No Specify: Specify: Baltimore, Maryland 21215-0036 the Medical Exac δ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 College (1-4or 5+) Furniture Elementary/Secondary (0-12) permit Pages 1 and 2 should be filed w Department of Health and Mental Hygier Imporant: If Itam 27 is marked other it any injury or other traumatic event, In once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Kaplan Harry Friedman 19b Mailing Address (Street and Number or flural Soute Number City 17 2m, State 50 50 King Farm Blvd., #104, Rock VIIIe, ... 19a. Informant's Name/Relationship (Type, Print)
Robin Friedman / daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Judean Memorial Garden Aug. 13, 2006 Olney, MD 1 Burial 2 ☐ Gremation 3 ☐ Removal from State 4 Donation 5 Oxfer (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Fun ray Service Licenses 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ong cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE MONTHS MULTI ORGAN **Physician** /Medical Due to (or as a consequence of) Examiner MONTHS SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physicien Completed by Physician/Medical signed by the attending d be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2 1 No certificate 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this nours after death.

nerei Director: After this filled in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending NIA 1 ☐ Yes 2 ☐ No NIA investigation NIA 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 🗌 Homicide NIA To the Hospital o within 24 hours aff To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D47722 AUGUST 12, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMEER SOFAT 15825 SHADY GROVE ROCKVILLE MD 20850 120AO,#60,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month Day

4 2006

32 Registrar's Signature

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H tificate of I	lealth and N Death	fental Hygid Rag	ene 2006	27313
'n			1. Decedent's Name (First, Middle, La	ist)			-	2. Date of Death Month	Day Year	3. Time of Death
	Physici /Media		Donald Ca	rl Ha	artman				14 2006	12:50P <sup>M</sup>
	Examir		4a. Facility Name (If not institution, gir			4b. City, Town, or	Location of Death		4c. County of Death	
h			Calvert Memoria	al Hospital		Prince I	rederick		Calvert	
	Funeral		,	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )	9. Birth	place (State or Foreign untry)
	Director		215-30-5295	LOS M ZUP	74 Yrs.			May 5, 1	1932 Balt	imore, MD
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Aaryli F sho	ō	MD Calvert		Lusby					1 ☐Yes 2 XNo
	28a-	Director	10e. Street and Number		Lusby	10f. Zip Code		100	g. Citizen of What Cou	intry?
	with	ā	12719 Mescalaro	Lano		2065	7	''	U.S.A.	,
	filed within 72 hours after death with the Maryland Hygiene. uther than "neturel", or items 23e or 28a-f show ant, the Madical Examinant tennified an	Funeral	11. Marital Status	12. Was Decedent 1	Ever in U.S. 13. \	Vas Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	ican Indian,
	r iter	Fun	1 Never Married 2 Married	Armed Forces?	· 1952-	f Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	Black, White	, etc.
3	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1955	I□Yes 21X No	Specify:		Specify: W.	hite
21215-0036	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Deced	lent's Usual Occupa	ation during most of work	ing 16	6b. Kind of Business/l	ndustry
21	thin and	ple	Elementary/Secondary (0-12)	College (1-4or 5	+) life. I	DO NOT use retired	1)			_
21	ad wi	Con		2	Civ	il Engine			<del></del>	Government
2	be filk tal Hy d oth even	Be	17. Father's Name (First, Middle, Las	1)				e (First, Middle, Ma	,	
<u>Ş</u>	Men Men arke	은	Louis Hartman,					et Eva So		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23e or 28e-f show any injury or other treumatic event, the Maxical Exactional be nutilised at once.		19a. Informant's Name/Relationship			ig Address <i>(Str</i> eet : Box 765			City or Town, State, Z	ip Code)
e n	item 27 is		Emily W. Hartman	1, Spouse	1 - 1 - 1		Lusby, M	1 8 1	De Leastine City of T	Farmer Change
0	ges 1 t of F If ite or ot		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 [	Removal from State		natory or other plac	:e)		oc. Location - City or 1	
Ē	tmen tent: jury		`4 □Donation 5 □ Other (Spec					16-06 A	lexandria,	VA
Baltimore,	permit Depar Impor eny in		21. Signature of Funeral Servic. Lice	nsee		. Name and Addres		D3 0	·	0726
	4020U	-0	Loty N 10	m.					ings, MD 2	
П			23a. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on each lin	the death. Do not ent			or respiratory arres	51,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a	espitor	4 +	adure			
	/Medical Examiner		1650 king in Gealtry	Due to (or as	a consequence of):	010				
ı.		<u></u>	Sequentially list conditions,	b. Due to (or as	a consequence of):	,,,,,				
	ted	nin	if any, leading to immediate cause. Enter Unionlying Cause (Disease or injury		OPD.					
	xecul al-tra	Examiner	that initiated events resulting in death) Last	c.	a consequence of):					<u> </u>
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal E		d						
687	tificate ng phy: as the	edlo		. 0.						
Вох	aath certif attending for use a	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3=			23d. Date of delin	very
ŭ	death a atte d for	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at		]Ectopic pregnancy ] Other (specify)			Month	Day Year
O.	that the death ed by the atte detached for	hys	9 🗆 Unknown	9L] Unknown						
٠ <u>.</u>	es tha igned l	y P	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Vital Records,	w require been sig should b							1 🗍 Yes	2 □ No 3 □ Pro	bably 4 Unknown
00	aw requas been 2 should	Completed						24a. Was an		opsy findings available
Re	The lav te has age 2	mo						autopsy performe 1 ☐ Yes ••••	gd? death?	ompletion of cause of
ta		(a)	25. Was case referred to medical	L			26. Place of Deat	h (Check only one)		
	Physicien: this certific ral director,	To B	examiner? 1 \( \text{Yes} \) 2 \( \text{Vo} \)	Hospital:	nt 2 ER/Outpatier	t 3 DOA Oth	er: 4 🗌 Nursing Ho	ome 5 Residen	ce 6 Other (Spec	ify)
ot	ig Physie ter this neral di	: 0	27. Manner of Death Natural 5 Pending	28a. Date of Inju (Month, Da)	ry 28b. Time of Injury	28c. Injun Worl	y at	28d. Describe how	r injury occurred	
Division	Attending r death. ector: After by the fune	atlo	2 Accident investigation	on			Yes 2 □ No			
<u> </u>	r Atte er de recto by th	tific	3 Suicide 6 Could not determined		ury - At home, farm, str	eet, factory, office		28f. Location (Stre	et and Number or Ru State)	ral Route Number,
	rs aft el Di	Certification;								
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier (Check only 2   Medical Exa	hysician: To the best of miner: On the basis of	of my knowledge, death	occurred at the tin	ne, date and place,	and due to the cau	use(s) and manner as	stated. to the cause(s)
	To the h within 24 To the F complete	ledi	one)	and manner sta	ated.					
	To To	Σ	29b. Signature and title of certifier	revolore	o Un	29c. Licens	060638	MD 290	d. Date signed (Month	
			/ / / .						- ,	
1	211		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type,	Print) 100	HOSPIT	NE RICH	ND 30	0678
1	ן דנ		30. Name and address of person who Nayantara Mendo 31. Date filed (Month, Day, Year) AUG 1	nca, M.D.	Signature	KINCE	-KE		יש עוא	- 0 , 0
	Sta Regist		AUG 1	6 2006	Grane M	Coast 1				
100	regist				THERTON JU.	Man and Man				

	1	State Registrar		Maryland / Dep	ertificate of	Death	2. Date of De	Reg. No.		3. Time of Death	
Physician /Medical		1. Decedent's Name (First, Middle, HAYWARD			HENRY		MAY	26	Year 2006	1847	
Examiner		ta. Facility Name (If not institution, THE JOHNS HO	OPKINS H	OSPIPAL	BALTIM	ORE	CITY		unty of Dea		
uneral irector		5. Social Security Number  2 14-32-5546  Usual Residence of Decedent	6. Sex 1 💢 M 2 🗆 F	7. Age (In yrs. last birthda 68 Yrs.	Months Days	Hours	Min. (Month, Da	th ay, Year) 1-1937		thplace (State or Foreig ountry) Maryland	
f show led at	-	10a. State 10b. County  DEL Susse	v	10c. City, Town or Seaford	Location					10d. Inside City Limit	
a or 28e	3	10e. Street and Number		Seaford	10f, Zip Code 19973			10g. Citizen	of What Co	ountry?	
it of nearly and well an hybertal in the man 23s or 28e-f show it if them 27 is marked other then "neturel", or item 23s or 28e-f show or other treumatic event. It is the Medical Examination must be neitified at To Be Commissed by Funeral Director	D L A	11034 Henry Dri  11. Marital Status  1 □ Never Married 2 ☒ Marrie 3 □ Widowed 4 □ Divorced	12. Was Dece Armed For	ces? 2 (X) X/o e	3. Was Decedent of h	an, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	D- 14.	Race - Ame Black, Whit ecify: B		
yylene. her then "neture t. the Modical E	n l l	15. Decedent' (Specify only highes Elementary/Secondary (0·12)	's Education t grade completed)  College (1-	4or 5+) (Gi	cedent's Usual Occup ve kind of work done b. DO NOT use retire	during most o			of Business	Onference	
Is marked other then eumatic event, Its M.	2	17. Father's Name (First, Middle, L Hayward Lankfor			5027 500	18. Mother	s Name <i>(First, Middle</i> erine Eliza	, Maiden Sur	name)		
27 Is mar r treumat	-	19a. Informant's Name/Relationsh Joan Joann Henr	nip (Type, Print)			and Number	or Rural Route Numb	er, City or To	wn, State,	Zip Code)	
Department of nearing important of the 27 is any injury or other tregores.	1	20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation  4 ☐ Donation 5 ☐ Other (Sp.		State cemetery, c	position (Name of rematory or other pla	' '	Date 05-31-06			Town, State	
Importent: any injury once.	Ī	21. Signature of the Library Service L				1	eral Home				
ysician		23a. Part 1. Enter ne disease, or shock, or hear failure. List of Immediate Cause (Final disease or condition resulting in death)	HYPE							Approximate Interval Between Onset and Death ONE DAY	
ledical aminer		Sequentially list conditions,		ISSW 3NG							
physician and sthe burial-transit	al Lyalling	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	PRIMAG	or as a consequence of property SCLEROS or as a consequence of):	ling Ch	COLANG	elfis			PEN YEAR	
the attending hed for use as	,	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐Live bi	ant at time of death	3 □Ectopic pregnanc 5 □ Other ( <i>specify</i> ) _	у		23d.	Date of de Month	livery Day Year	
be d	2	Part II. Other significant conditio	ns contributing to de	ath but not resulting in the	e underlying cause gr	ven in Part I.		tobacco use o		o the cause of death?	
page 2 should	and income								4b. Were an prior to death?	utopsy findings availab completion of cause of 2 No	
Mer this certificant and director.	200	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending  2 Accident investig	28a. Date o	npatient 2 ER/Outpat of Injury 28b. Time h, Day Year) Injury	of 28c. Inju	her: 4 🗆 Nurs	of Death (Check only sing Home 5 Resi	idence 6 🗆		icity)	
el Director: Atter funera led in by the funera Certification:		3 Suicide 6 Could n 4 Homicide determi	ned 200. Place	of Injury - At home, farm, ng, etc. (Specify)	street, factory, office			Street and Ni wn, State)	umber or R	ural Route Number,	
200				best of my knowledge, de sis of examination and/or er stated.							
ne Fune ne Fune netely fill		29b. Signature and title of certifier	61	_	29c. Licen	se number		29d. Date si	gned (Mont	h, Day, Year)	
within 24 hours after beam. To the Funerel Director: A completely filled in by the to Madical Certificati	DIA	> Illout	) , M	D	RES	-000		MAY	27.	2006	

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydien 2006

1-	For State Registrar	State of Mary		artment of H		F	Reg. No.	27315
Dhysisian	Decedent's Name (First, Middle, Last Raymond L. Hoffma					2. Date of Dea Month	Day Yea 11, 2006	3. Time of Death  3:10 a. M
/Medical	. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea		4c. County of De	
Examiliei	9009 New Cut Road			Rocky			Frederic	
runeral	Social Security Number 6. Se	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	n (Month Da	10, 1923	Firthplace (State or Foreign Country)  Maryland
Us	20-16-0743 sual Residence of Decedent	- 03				Dandery	10, 1, 23	
anyland 10	Da. State 10b. County		c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2☐No
with the Ma or 28a-fe to nutfled	aryland Frederic	k R	ocky Rid	ge 10f. Zip Code			10g. Citizen of What	
with t	9009 New Cut Road	L		21778			USA	
al, or iter Exercities	I. Marital Status  1 Never Married 2 Narried  3 Widowed 4 Divorced	12. Was Decedent Evel Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 A No	Specify:	(Specify Yes or No erto Rican, etc.)	Black, W Specify:	white
72 hg	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of v	vorking	16b. Kind of Busines	ss/Industry
ed within 72 ho ygiene. ier than "netur. t, the Madical Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		nt worker	,		Capito1	Milk
De filed to their to the to their to their to their to th	7. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,		
Menta Menta arked artic e artic e	George Elmer Hof					Hankey	- O't - T Chat	Zin Codo)
12 show hand hand reeum	9a. Informant's Name/Relationship (7 Shirley Hoffman -	* *					er, City or Town, State	
Theatt	Da. Method of Disposition		20b. Place of Dispo	1100		Date	20c. Location - City	
Pages ent of nt: If if	1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			Memorial		5-2006 F	rederick,	Maryland
	21. Signature of Funeral Service Licen	wile to	leve 1	621 Uposs	untown	Pike, Fre	Funeral Ho derick, Ma	
Physician	23a. Part1. Enter the disease, or com, shock, or heart failure. List only mmediate Cause (Final disease or condition resulting in death)	one cause on each line.						Approximate Interval Between Onset and Death
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ansit	Sequentially list conditions, any, leading to immediate ause. Enter Underlying Jause (Disease or injury hat initiated events esulting in death) Last	b. Due to (or as a c	onsequence of):  onsequence of):	chul v	rschir	r Aan din		Zwels
oo difficate as the as the ledic		0.						
death death of for a	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of page 1	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	delivery Day Year
be d	art II. Other significant conditions of	ontributing to death but r	not resulting in the	underlying cause gr	ven in Part I.			e to the cause of death?  Probably 4 Unknown
The la							ormed? deat	autopsy findings available to completion of cause of n? Yes 2 \( \sum \text{No} \)
VITAL IN SICIAN: The certificate irector, page Co	25. Was case referred to medical examiner?	Hospital:		Ott	hor	Death (Check only		
ig Physical distriction of To To To To To To To To To To To To To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigatio	28a. Date of Injury (Month, Day Y		of 28c. Inju	4 LINUISIII		idence 6 Other (S how injury occurred	Specify)
DIVISION OF Hospital or Attending P 24 hours after death. The Funerel Director: Attent Director titler in by the funerel direct Certification;	2 Accident investigatio 3 Suicide 6 Could not be determined	e 290 Place of Injury		treet, factory, office			Street and Number o wn, State)	r Rural Route Number,
Hospi 4 hou Funer Fely fill	29a. Certifier (Check only one)  1. Certifying Pl 2. Medical Example 1. Certifying Pl	nysician: To the best of a niner: On the basis of ea and manner state	xamination and/or i	ith occurred at the t nvestigation, in my	me, date and ploopinion, death o	lace, and due to the occurred at the time	cause(s) and manne, date and place, and	r as stated. due to the cause(s)
To the within 2 To the complete	29b. Signature and title of certifier	01	(	29c. Licen	se number	11	29d. Date signed (M	fonth. Day, Year)
	My UV	ewyn c	x no	- 04	1199	7	8/14	104
6	30. Name and address of person who	completed cause of dea	th (Item 23a) (Type	Thomas to	hnun	DUE	frederick	COS150M
State Registrar	De Date (Hard (Month Con Vone)	2006 32 Segistrar's	s Signaturo	book	-19( 4			Contin. Day, Year)  LOG  MO 7/707

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2005 27316 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2006 Physician Harry Aug. 12, Virgil Johnson 9:25a M /Medical 4a. Facility Name (# not institution, give street and number)
Williamsport Nursing Home 4b. City, Town, or Location of Death Williamsport 4c. County of Death **Examiner** Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec 13,1925 Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1**X** M 2□ F 80 219-20-2345 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State MD e filed within 72 hours after death with the Marylan al Hygiene, in the first in the state of 28e-f show to the Medical Examiner must be nutilised at Clear Spring Washington 1 ☐ Yes 2 No Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 12259 Boyd Road 21722 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? XGYes 2 □ No WWII If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Specify: White 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) truck mfq Elementary/Secondary (0-12) College (1-4or 5+) inspector 8th grade 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Heelth and Mental Hillant: If Itam 27 is marked off Gordon Roy Johnson Rhoda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael Johnson son P.O.BOX 51 Clear Spring, MD 21722 20c. Location - City or Town, State
Smithsburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 8-14-06 20a Method of Disposition ö 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Dapartment of important: if any injury or once. Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Donald Edwin Thompson Funeral Home, P.O.BOX 310 Clear Spring, MD 21722 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA 48 Hours Pnysician /Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMOWARY DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physicien and s the burial-transit or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical attending physical for use as that IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached of Vital Records, P.O. 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HEART FAILURE CONGESTIVE 1 DAYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 No After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27, Manner of Death Division 1 Natural 5 Pendina 1 Tes 2 No within 24 hours efter death. To the Funerel Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D33700 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13H-20+1 WILLIAMSPORT. 54 N. ARTIZAN ST. IEDE. HOWE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 16 2006 Registrar

06-06082

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Paul Anthony Kovacs 2006 27317 1- For State Certificate of Death Reg No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 1922 hrs Medical Examiner August 15, 2006 Paul Anthony Kovacs

4a Facility Name (if not institution, give street and number 4b City Town or Location of Death 4c County of Death 23264 By The Mill Road California St. Marv's 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number If Under 1 Year If Under 24Hrs. 9 Birthplace (State or Age (In vrs. last birthday) **Funeral** Months Days Hours Director 216-15-3247 July 22 1981 CountryMaryland 1X M 2 25 Usual Residence of Decedent 10a, State Ob. County I0c. City, Town or Location 10d Inside City Limits Maryland Calvert St. Leonard 1 Yes 2 XNo 28a-f show , or items 23a or 28a-f shorr must be notified at once. with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2141 Timeless Drive 20685 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc hours after death 1 XNever Married 2 Married Vec 2 3 No white Yes 2 X No specify Widowed 4 Divorced f Yes. Give Year Specify 'natural". 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 6b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 I nen of Health and Mental Hygiene ant: If item 27 is marked other than "n or other traumatic event, the Medical E MD 21215-0036 12th installation carpet/flooring 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Pamela Turkette

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilfredo Kovacs 19a. Informant's Name/Relationship (Type, Print) Pamela Quade - mother 2141 Timeless Dr. St. Leonard, MD 20685 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 19 2006 St. Leonard Maryland Waters Memorial Cemeté ment c Donation 5 Other Specify or 22. Name and Address of Facility 21. Signature of Euneral Service Licenses Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD 20676 d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician 23a. Part I. Enter the disease, complications that c failure. List only one cause on each line Between Onset and /Medical Chlorodifluoromethane intoxication Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of). cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and ician/Medical XUNPENDED ysician AMENDED item#23a.27.28a-f.perME.g858.8/31/06 TT Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy ing physas the b 23d. Date of delivery 23b. Was decedent pregnant in the Live hirth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) detached for 1 Yes 2 No 9 Unknown 9 Unknown ould be detache 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? certificate ✓ Yes 2 No 1 🗸 Yes 2 Nο 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient 2 Other: Nursing Home 5 Residence 6 🗸 Other: Scene After this ER/Outpatient 3 DOA 1 🗸 Yes No ٩ 28a Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 1 Natural 5 Pending 2 Accident

Hospital or Attending Physician:

Certification: /s after dea....al Director: Af 24 hours a Medical within 2 To the

3

(Check only

1 Yes 2 y No Fnd 8/15/2006 | Fnd 7:20 pm unk Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be 23264 By The Mill Road or Town, State) determined Found: residence (outside/ rear of) California.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and fitte of certifie

29c. License number OCME

29d Date signed (Month, Day, Year) August 16, 2006

of person who complet id cluse of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) -State Registrar

Susan Hogan MD.

Suicide

Homicide 29a. Certifier 1

			1 - For State Registrar	Sta	ite of M	laryland	-	artmen rtificat			and M	ental Hy	giene 0	06	27318
t	Physicia		1. Decedent's Name (First, Mid ANNI G.	dle, Last) KNUTS	ON							2. Date of De. Month AUGUST	Day	Year 2006	3. Time of Death  12:50 PM
	/Medic		4a. Facility Name (If not institut			)		4b. City,	Town, or	Location o	of Death	AUGUSI	4c. Count		12:50 F
			NATIONAL LUT							VILLE				rgome:	
į.	Funeral Director		5. Social Security Number 400-48-3871	6. Sex 1 ☐ M 2		ge ( <i>In yrs. l</i> as 84	t birthday) Yrs.	If Under Months	Days	If Under: Hours	Min.	8. Date of Bird (Month, Da July	1 1922	Cour	lace (State or Foreign etry) ermany
	D		Usual Residence of Decedent		L	T 40 - 01 - 3	F								Od. Inside City Limits
	Aarylar F show	ō	Md . 10b. Coun	w ontgome	ry	10c. City, T	ckvi							'	1 ☐ Yes 2 XNo
	r 28a-	irect	10e. Street and Number	<del>-</del>			-	10f. Zip	Code				10g. Citizen of	What Cour	itry?
	23a o ust be	rai D	3 Dabney Cou	rt						2085				ed Sta	
336	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Exactical reast he inclined at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ M 3 ☐ Widowed 4 ☐ Divorc	Arried 1 [	as Decedent med Forces Yes 2 Yes, Give har or Dates:	No		Was Deced If Yes, spec 1 ☐ Yes		spanic Ori n, Mexican Specity:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	Specia	ce - Americ ck, White, fy: Wi	
2-0	72 hor	eted	15. Deced (Specify only high	ent's Education	pleted)		(Give	dent's Usua kind of wo	rk done o	turing mos	t of worki	ng	16b. Kind of E	Business/Inc	dustry
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12	) Co	ollege (1-4or	5+)		omema		)			Own Ho	ome	
		To Be Co	17. Father's Name (First, Middle Gustav Des	e, Last)	0	<u>,                                     </u>					er's Name	(First, Middle, Rutz	Maiden Surna	me)	
Maryland	s 1 and 2 should be f Health and Mental item 27 Is marked othar traumatic ev	-	19a. Informant's Name/Relatio			1		ng Address abney				Noute Number	Md. 2	, <i>State, Zip</i> 2 <b>0</b> 853	Code)
ore,	t. Pages 1 and the all	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematio	n 3 □Bemov	al from State	Cen	e of Disponentary, crea	osition (Nar matory or c	ne of ther place	θ)		ate	20c. Location	- City or To	wn, State
Baltimore,	untment untant: Pag untant: I		`4 □ Donation 5 □ Other	(Specify)				's Ce			8/12		Redland	d, Ma	ryland
Bal	permit. Departmine importa any inju		21. Signature of Funeral Service	W.	Bar	her		P. 0	. B	ox 50	38,	Funeral Laytons	sville,	Md.	
	Physician		23a. Part1. Enter the disease, shock, or heart failure. LImmediate Cause (Final disease or condition resulting in death)	a.	each each	e bro	OV	asc	e of dying	g, such as	pardiac c	or respiratory a	rrest,	1	Approximate Interval Between Onset and Death
	/Medical Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Due to (of a	s a conseque	bro	ein	M	alie	7 no	ince		1	Months
60,	death certificate be executed e attending physician and nd for use as the burial-transit	al Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	e to (or a	s viconseque	nce of):	7	4~	de.	eu Se	ure.		/	Vonthy
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O. Box	that the death certifica ed by the attending pl detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 monubs? 1 □ Yes 2 ☑ No 9 □ Unknown	1(	Live birth	e of pregnanc 2  Fetal d at time of dea	eath 3	⊒Ectopic pi ⊒ Other (sp						ate of delive	ery Day Year
rds, P	Se US	by	Part II. Other significant cond	inions contribut	ing to death	but not resulti	ing in the L	inderlying o	ause give	en in Part I		23e. Did t			ne cause of death?
Records,	The ate h page	Completed	Chronie	Nen	d, h	seff	(ue	reg			_	24a. Was auto perfo 1  Yes	osy ermed?	Were auto prior to co death? 1 \( \subseteq Yes	psy findings available mpletion of cause of
Vital	ii iii ii	Be	25. Was case referred to med examiner?	cal Hospita	al-				Oth			(Check only			
of	ding Phys h. After this funeral di	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pen 2 Accident	28	a. Date of In (Month, D	tient 2□EF jury 2 ay Year) 2	NOutpatie 8b. Time o Injury		28c. Injun Work	/ at			dence 8 🗆 Ot how injury occu		y)
Division	al or Attendi after death. I Diractor: A d in by the fu	Certification:	3 Suicide 6 ☐ CoL	ld not be 28	e. Place of li building, e	nj <i>ury -</i> At hom etc. <i>(Specify)</i>	e, farm, st	reet, factor	y, office			28f. Location ( City or To		ber or Rura	I Route Number,
	To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completely filled in by the	edical C		ying Physician al Examiner: ( a		of examinatio									
)	withii To th	M	29b. Signature and title of cert	er a	I Ca	resh	M	29	c. License	e number	46		29d. Date sign	1	Day, Year)
	9		30. Name and address of pers Charles W.		M.D.	970	1 Vi	Print) ers D	rive	, Roc	kvil	le, Md.	2085	50	
	Sta Regist		31. Date filed (Month, Day, Ye AUG 1	4 2006	32 Aegis	strar's Signatu	re	parti	,						

		ĺ	1 - State Registrar	State of Marylar	nd / Depa <i>Cer</i>	artmer tificat	nt of H te of L	ealth and Death	F	Reg. No.	06	27319
	Physici	an	Decedent's Name (First, Middle, Last						Date of Dea     Month	Day	Year	3. Time of Death
Н	/Media	al	Meriam  4a. Facility Name (If not institution, give	Catherine	Ki		Tourn or	Location of Dea		16, 200 4c. County		6:30 p <sup>M</sup>
	Examin	ier	Williamsport N					iamspor				
	Funeral	-	5. Social Security Number 6. Se	x 7. Age (In yrs.		If Under	r 1 Year	If Under 24 Hrs Hours Min	8. Date of Birth	1	9. Births	gton place (State or Foreign ntry)
	Director		219-12-2306	<sup>□ M 2</sup> XF 82	Yrs.	MOTHITS	Days	Hours Min	June 8	1924	Mar	ÿland
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					1.	10d. Inside City Limits
	Mary Iled	ţō	Maryland Washi	ngton	Will	iams	port	<del>-</del> .				1 <b>X</b> □Yes 2□No
	n the	Director	10e. Street and Number	3		10f. Zip	·			10g. Citizen of V	Vhat Cou	ntry?
	th wit	ai D	154 North Arti	zan Street			2179	95		U.S.	Α.	
	er dea	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Vas Dece f Yes, spe	dent of Hi	spanic Origin? ( n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Rao Blac	e - Americk, White,	can Indian, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	1 ∐ Yes 2 <b>)(</b> ) No If Yes, Give Year or Dates:		I □ Yes	2 <b>X</b> No	Specify:		Specify		ite
Ş	2 hou	ted	15. Decedent's Edu	ucation	16a. Deced	lent's Usu	al Occupa	ation		16b. Kind of Bu	ısiness/în	dustry
215	thin 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5+)	(Give	kind of wo DO NOT u	ork done d ise retired,	furing most of wo	orking			,
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and	ntal H ed otl	Be	17. Father's Name (First, Middle, Last)						me (First, Middle,			
Maryland 21215-0036	should nd Me mark matic	၉	George  19a. Informant's Name/Relationship (7)		Ralls	n Address	s (Street a		lbeth Bural Route Numbe			dicord
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ore,	of Her		20a. Method of Disposition	20b. I	Place of Dispo	SILIUM (TVAI	me or		lling War	20c. Location -	City or 10	own, State
altimore,	Pege nent c		1 ⊠ Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,	nemovar from State	est Hav	•		erv   Aug	.18,2006	Hagersto	own.	Maryland
Balt	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Importent: If Item 27 is marked other then "natural", or iteme 23s or 28s-f show eny figury or other traumatic event, the Medical Examinar must be notified at ance.		21. Signature of Funeral Service Licens		22	Name ar	nd Addres	s of Facility	Funeral	Homo Tr	20	319.2 3.000
_	20 = 0		R. Roel B	rady	46	Las	t Ant	tietam S	treet. H	agersto	vn, M	1d. 21740
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68760,	ificate be executed g physicien and as the burial-transit	edical		d								
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Ď.	death le ette ad for	Physician/M	in the past 12 months?	1☐Live birth 2☐Feta 4☐Pregnant at time of c		Ectopic p Other (sc				Moi		Day Year
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Division of Vital Records, P.O.	The law requires thet the death cert ste has been signed by the ettending page 2 should be detached for use a	þ	Part II. Other significant conditions co	ntributing to death but not res	sulting in the ur	nderlying o	cause give	in in Part I.				he cause of death?
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Rec	hasl ge 2 s	E G	osteoporos	5					24a. Was a autop perfor	sy p	Vere auto prior to co leath?	opsy findings available impletion of cause of
ē	ificete or, pa	ပိ	25. Was case referred to medical						1 ☐ Yes	2 <b>Y</b> No 1	Yes	2 □ No
<u> </u>	Attending Physician: r death. ector: After this certifice by the funeral director, p	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 🗆 D C	Othe	r /	ath <i>Check only or</i> Home 5 ☐ Resid		er (Specif	6/1
<u>0</u>	ng Ph ter th	L:u	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work		28d. Describe h			<i>y</i> /
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N N	l or At efter d Direct Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, stri	eet, factor	y, office		28f. Location (S City or Tow		er or Rura	al Route Number,
_	To the Hospital or Attending Physician: The law requires thet the death certif within 24 hours effect death.  To the Funeral Director: Affer this certificete has been signed by the ettending to the Funeral Director. Affer this certificete has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier 1 Certifying Phy	sician: To the best of my kno	owledge death	Occurred	at the tim	e date and also	e and due to the	auca(s) and =		totad
	To the Hospital within 24 hours of the Funeral completely filled	edical	(Check only 2 Medical Exam	iner: On the basis of examina and manner stated.	ation and/or inv	estigation	n, in my op	inion, death occ	urred at the time, o	late and place, a	nner as s and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				c. License		1	29d. Date signed		
				ittner-Sar				7451		angus.	+ 17	,2006
31	4-3		30. Name and address of person who c	ompleted cause of death (Iter	m 23a) (Type,	Print)		Nursin	g Home	, 154 1	10r	th Artizar
			Cynthia Kuther 31. Date filed (Month, Day, Year)	-Sands MD  32. Begistrar's Signs	WILL CO	insp	7 10		Street,	Williams	SPOC	+, Mary Tan
	Sta Registr		ST. Date filed (Mortin, Day, Tear)	oz. gogiotiai o otigin	A A	. 1.1						

Meriam Catherine Kirk

			For State Registrar	State of Marylar		rtment of tificate o			ental Hyg	iene <sub>g. No.</sub> 2 (	006	27320
			Decedent's Name (First, Middle, Last)					2	2. Date of Deat Month		Year	3. Time of Death
	Physicia /Medic		JAMES ROBER	T LOUDEN					August	11	2006	3:45 P M
1	Examin		4a. Facility Name (If not institution, give s		C- 1-	4b. City, Town					y of Death	.,
			Brooke Grove Rehab  5. Social Security Number 6. Sex	. and Nursing		f Under 1 Ye	dy Spr		B. Date of Birth		gomer 9. Birtho	<u> </u>
	Funeral Director			M 2□F 86	Yrs.	Months Da		Min.	Month, Day, Dec. 11	.1919	West	place (State or Foreign htry) Virginia
			Usual Residence of Decedent							,		
	how		Md. 10b. County Md. Montgome		ty, Town or Loc Olney	cation					1	0d. Inside City Limits 1 ☐ Yes 2 No
	8a-1 e	cto		У	Officy	1401 7 0 4				0g. Citizen of	What Cour	
	with th	20	10e. Street and Number 19457 Olney Mill	Poad		10f. Zip Cod 208				United		
	eath ns 23	by Funeral Director		2. Was Decedent Ever in U	l.S. 13. V	Vas Decedent	of Hispanic O	rigin? (Spec	fy Yes or No-	14. Ra	ce - Americ	can Indian,
က	or iten	표	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No WW	II	Yes, specify C			ican, etc.)		ack, White,	
ğ	within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28a-f ehow he Madical Exeminer must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:				, 		Speci	Wn	ite
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12	within Bne. than	Juno	Elementary/Secondary (0-12)	College (1-4or 5+)		ical En				Chemi	cal C	ompany
פ	Hygi other	Be Co	17. Father's Name (First, Middle, Last)		,				(First, Middle, I			omp.wity.
lan	should be filed within and Mental Hygiene. s marked other than "sumatic event, the Mar	To B	Herbert Louden							ester		
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents if item 27 is marked other than "naturel; or items 23a or 28a-1 show amportents if item 27 is marked other than "naturel; or items 23a or 28a-1 show amplical Extending must be notified at an ancie.	. 9	19a. Informant's Name/Relationship (Ty)						Route Number			Code)
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ᄩ	artme orteni influro		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License						neral H			0000
Ba	permit Depar Impor any in		1 murief &	1. Bark	er Mi	uriel H	. Barb	er ful	neral H tonevil	ome		0882
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the dea	th. Do not ente	er the mode of	dying, such a	as cardiac or	respiratory arr	est,	•	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Myo Cas.  Due to (or as a conse	dial i	in far	e Han					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):							
	Examine	J.	Sequentially list conditions, if any, leading to immediate	Due to for as a conse	quaries of):							
	uted I	Examiner	cause. Enter Underlying Cause (Disease or injury									
ď.	sicien and burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a conse	quence of):							
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S, P	The law requires that the site has been signed by thogge 2 should be detache	by Pl	Part II. Other significant conditions con		sulting in the u	nderlying caus	e given in Par	t I.	23e. Did to	bacco use co	entribute to	the cause of death?
rds	en sig	ed	<u>Lardiomyo</u>	sathy					1 U Y	'es 2□No	3 Pro	bably 4 dunknown
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<u>=</u>		Con							perfor 1 ☐ Yes	2 No	death?	2 No
Vita	Physician: Tripis certifical	Be	25. Was case referred to medical examiner?	Hospital:			Othor		(Check only or			
o	Phys this ral dii	7	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Injury	28b. Time o		Injury at Work?		ne 5 🗆 Resid			(Y)
0	Attending In death.	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м	Work? 1 ☐ Yes 2 [	□No				
Division	or Attendiater death.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec		reet, factory, of	fice	2	8f. Location (S City or Tow		nber or Rui	al Route Number,
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	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical Exam	sician: To the best of my ki ner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the vestigation, in	he time, date my opinion, d	and place, a leath occurre	and due to the o ed at the time, o	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
	thin 2 thin 2 or the	Med	one) 29b. Signature and title of certifier			29c. Li	cense numbe	or .		29d. Date sig	ned (Month	, Day, Year)
	F 3 F 8		10000	renus		D	3979	3		Augu	at 14	, 2006
/	0+1		30. Name and address of person who c	ompleted cause of death (Ite	em 23a) (Type,	Print)				. 0		
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State of Maryland / Department of Health and Mental Hygiene 2006 27321 For State Registra Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician Macri Logan 2006 8:30 a Carmella 11, August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Sunrise House If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 25, 19 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months 1 ☐ M 2 🖾 F 1927 79 025-26-8514 Maine Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County d'Hygiene. . other then "natural", or liems 23a or 28e-1 ehow vent, the Medical Examinar natat be notified at 1 □Yes 2 No Directo Montgomery Rockville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe #418 20850 IISA 8 Baltimore Road, Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 28 No 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specialhite δ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Flementary/Secondary (0-12) 4 Medical Technology Biologist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Menta Pages 1 and 2 should be Giovanna Esposito ie marked Domenic Macri ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2
Department of Health a
Importent: if item 27 is
any injury or other trat 8312 Tea Rose Drive, Gaithersburg, MD 20879 Michelle Michaelis/ Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 18, August 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 2006 Silver Spring, Maryland 22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee Son S cames 500 University Blyd, W. Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part n. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** a Cerebral Hemorrhage /Medical Due to (or as a consequence of): Examiner b Breast Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of): The law requires that the death certificate be executed c. Hypertension
Due to (or as a consequence of): that initiated events physicien and resulting in death) Last Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for u Year in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) detached Division of Vital Records, P.O. 9 ☐ Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown been sign 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate 1 ☐ Yes 2 XNo Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other  $_{4\square \, \text{Nursing Home}}$  5  $\square \, \text{Residence}$  6  $\square \, \text{Other} \, (\textit{Specify}) \, \text{Assisted}$ 1 ☐ Inpatient 2 ☐ ER/OutpatienI 3□ DOA ဥ 1 ☐ Yes 2 XNo this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Living 27. Manner of Death Certification: s after dea. 1 Natural 5 Pending 1 □Yes 2 □ No investigation 2 Accident 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 6 ☐ Could not be 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide illed in by 4 | Homicide 0 To the Hospital o within 24 hours aff To the Funerel Di 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of D35792 August 11, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edmonston Drive, Rockville, MD 20852 Rao Nav. Year) 50 W Edmonst 32. Registrar's Signature M.D. State

Registrar

State of Maryland / Department of Health and Mental Hygiene 27322 Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Dorothy Althea Adams Line August 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown Washington County Washington County Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 💢 F Yrs Virginia Director 1925 Feb 11 219-14-7793 Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23s or 28s-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 11 Chartridge Dri Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

| Continued to the continued of th 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) and Mental Hygiene. 10 Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 end 2 should be fill ment of Heelth and Mental H lant: If Item 27 Is marked ot Mazie Sedalia Stover David Robert Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Chartridge Drive Hagersotwn Maryland 21742 Donald Merrick Line (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: if eny injury or once. Aug 18 2006 Hagerstown Maryland 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause of each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner signed by the ettending physicien and d be deteched for use es the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mopt Month 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 25 MG 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ MG Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Yes / 2 | DAO 1 | Inpatient 2 P/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina 1 Tes 2 No death. after death 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral L 29a. Certifier 1 (Destitying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 5H-6 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 16 2006 Registrar

DHMH 17 Rev 1/2001

			For State Registrar		State o	f Maryl	land / Dep <i>Ce</i>	artmer ertifica	nt of H	lealth a Death	and Me	ental Hyg	giene Reg. No	2006	5	273	23
T			1. Decedent's Name (First, M.	ddle, Las	t)							2. Date of Dea	ath Da	v Ye	er	3. Time of D	eath
	Physici /Medio		Mae Louise	McC1:	anahan							August		•		5:40 1	РМ
	Examin		4a. Facility Name (If not institu			mber)		4b. City	Town, o	r Location o	of Death		40	. County of E	Death		
1			Calvert Memo	rial	Hospit	al				Frede				Calver			
	Funeral		5. Social Security Number	6. Se	ex □M 2 <b>]</b> X]F	7. Age (In	yrs. last birthday	) If Unde Months	r 1 Year Days	If Under:	Min.	<ol> <li>Date of Birt (Month, Da)</li> </ol>	y, Year)	9.	Birthpla Country	ce (State or I	Foreign
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	and *		Usual Residence of Decedent  10a. State 10b. Cou			10c	:. City, Town or L	ocation	-	-					100	d. Inside City	Limits
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Division of Vital Records,	s cert	To Be	examiner? 1 ☐ Yes 2 ☑ No	-	Hospital:	Inpatient	2 XER/Outpatio	ent 3 D	OA Oth			ne 5 ☐ Resid		6 □Other (	Specify)		
o	a Phy er this		27. Manner of Death		28a. Date	of Injury	28b. Time		28c. Injur	y at	-	8d. Describe h			, , , ,		
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	To the Hospital or Attending Physicien: The I within 24 hours efter deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director. page	) B					knowledge, dea mination and/or i										
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			30. Name and address of per	son who c	completed cau	se of death	(Item 23a) (Type	Print)	Λ	1		Λ,	Or I	7/7/1			
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	Regist	rar	A	JG 1	5 2006	/Sist	en s	So	we	,							

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 006 1 - For State Registrar 27324 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ian Edward McGlamry August 13, 2006 11:49 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert Date of Birth (Month, Day, Year) 2003 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1**X** M 2 □ F Texas 635-88-0103 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b County 10a State 7 is marked other than "netural", or items 23a or 28a-f show traumatic svent, it a Madical Examiner must be notified at 1 ☐ Yes 2X No Director MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20639 3252 Solomons Island Road IISA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 and 2 should be filed within 72 hours after o Health and Mental Hygiene. 5m 27 Is marked other then "netural", or Iter 1 Never Married 2 Married ☐Yes 2X No Yes. Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A 0 Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be McGlamry Jeremy Cara Hayward ం 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 i Huntingtown, MD 20639 Cara McGlamry (mother) 3252 Solomons Island Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Aug I8 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Southern Mem. Grdns. 4 ☐ Donation 5 ☐ Other (Specify) 2006 Dunkirk, MD 21. Signature of Fu service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA ₹. GOT 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or Examiner Se juential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ( as a onsequence of). Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 1 → Yo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1 Yes 2 NO Hospital or Attending Physicien: 25. Was case rred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 2 P/Outpatient 3 DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner eath 28b. Time of 28d. Describe how injury occurred Certification; After 5 Pending investigation Matural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 20b. Signature and title of certifier 106 30. Name and address of person who completed cause of death-(Item 23a) (Type, Print) W Qt MON Date filed (Month, Day, Year) 32. Registra Signature State AUG 5 2006 Registrar

			for State Registrar	State of Marylan				lealth an Death	d Me			106	27325
			1. Decedent's Name (First, Middle, Last,						2.	Date of Death Month	Day	Voor	3. Time of Death
	Physici /Medio		Phon Meas						J	uly 29,		Year )	5:15 P M
k.	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or	Location of D	eath		4c. Coun	ty of Death	
			Randolph Hills Nu	rsing Home			Silv	er Spr	ing		M	lontgo	merv
	Funeral		5. Social Security Number 6. Se:		- "	If Und	er 1 Year	If Under 24		Date of Birth (Month, Day,	(ear)	9. Birth	place (State or Foreign ntry)
ш	Director		224-35-4390	M 2□F 91	Yrs.	171011111	34,5	1.00.0		lay 5, 1		1	bodia
	pu k		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Lo	aation							10d. Inside City Limits
	anyla eho	ř											1 ☐ Yes 2X No
	Ba-f	ecto	Maryland Montgo	mery S	ilver	-							
	vith ti	ä	10e. Street and Number			10f. Z	p Code			10	g. Citizen o	f What Cou	ntry?
	ath v	a	13800 New Hampshi				20904				USA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow important: If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow any intry or other traumatic event, it is Midical Examinant to incitified at ADES.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	f Yes, sp	edent of Hecify Cuba 2 2 No	ispanic Origin in, Mexican, P Specify:	? (Specifi uerto Ric	y Yes or No- an, etc.)			
Ŷ	2 ho	ted	15. Decedent's Edu		16a. Deced	lent's Us	al Occup	ation		11	6b. Kind of	Business/In	
풊	hin 7	Pe Pe	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT	ork done d use retired	during most of	working				
7	d wit	PO	8		Monk						Rel	igion	
	e file al Hy oth	BeC	17. Father's Name (First, Middle, Last)					18. Mother's	Name (F	First, Middle, Ma	aiden Suma	ıme)	
Ja	uld b Venti	To	Unobtainable					Uno	btai	nable			
Maryland	and /		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Addres	s (Street	and Number o	r Rural R	oute Number,	City or Tow	n, State, Zip	Code)
Baltimore, M	of Health of Health if item 27		Sovan Tun/Persona  20a. Method of Disposition  1 □ Burial 2 ② remation 3 □ F	20b. P	ive 1: Place of Dispo	sition (Na	ime of		ire .			Sprin - City or To	
Ĕ	Pag ment ent: 1		4 □Donation 5 □ Other (Specify)		. Lince	oln (	Crema	tory A	ug 5	, 2006	Bren	twood	, MD
ä	Departimport import pnce.		21. Signature of Funeral Service Licens	000	22	. Name a	ind Addre	ss of FacilityH	ines	-Rinald	i Fun	eral	Home
<u> </u>	g Q ;		1 Way	Lames	1.	1800	New	Hampsh	ire .	Ave, Si	lver	Sprin	g, MD 20904
<u>-</u>	Physician		23a. Part1. Enter the disease, or combot shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	cations that caused the death ne cause on each line.				g, such as car sease	rdiac or re	espiratory arres	it,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):								
	3.	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):								
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury									-	
	al-tra	Xa	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):								
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687	ficate p phy s the										-		
P.O. Box	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic (	oregnancy pecify)					ate of delive fonth	ery Day Year
	res that tigned by	<u>e</u>	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the ur	nderlying	cause give	en in Part I.		23e. Did toba	cco use co	ntribute to the	he cause of death?
Division of Vital Records,	Physician: The law requires that the this certificate has been signed by the rail director, page 2 should be detach	d by	Congestive Heart	Failure						1 🗌 Yes	2 <b>X</b> No	3 🗌 Prot	pably 4 Unknown
င္ပ	w requir been si should	Completed	-							24a. Was an	24h	Were auto	opsy findings available
Re	he la e has ge 2	Ē								autopsy			mpletion of cause of
a	n: T ficate or, pa	e Co	OF Man area referred to madical								No	1 🗌 Yes	2 No
⋚	sicia	00	25. Was case referred to medical examiner?	lospital:	<b>FR</b> (0)		Oth			Check only one,			
of	Phy r this	5	1 ☐ Yes 2 📉 No  27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of		UA	4AL Nursin		5 Residen			(y)
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Si	Attending or death. ector: After by the fune	Ica	3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome farm str					Location (Stre	et and Nun	ther or Rurs	al Route Number,
2	후	i Certification:	4 Homicide determined	building, etc. (Specify	y) 					City or Town,	State)		
	the Hospital hin 24 hours the Funeral hpletely filled	edicai	29a. Certifier 1 A Certifying Physics (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	tion and/or inv	estigatio	n, in my o	ie, date and p pinion, death o	occurred	at the time, dat	se(s) and n e and place	nanner as s , and due to	stated. o the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	7	7	29	c. License	e number		290	I. Date sign	ed (Month,	Day, Year)
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•	1		30. Name and address of person who co	impleted cause of death (Item	1 23a) (Type	Print)	222				11ugu	10	, 2000
	1		Alan R. Segal, MD	1517/Hugo C			Spri	na MD	2001	06			
	Sta	te	31. Date filed (Month, Day, Year)	32. Tegistrar's Signa	iture	VEI	PPLI	ALE PILL	2071				
	Registr		AUG 1 4 20	32. Anglistrar's Signa	b. Do	CALL	,						

State of Maryland / Department of Health and Mental Hygien 2006 27326 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6:40Am **Physician** RAMA ALICE MCNAMEE HUGUS7 16,2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2**X** F 212-24-5585 Director Vrs MARCH 12, 81 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show f Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23a or 28a-f shov other treumatic event, the Medical Examinar must be notified at Director MARYLAND WILLIAMSPORT 1 Yes 2 No WASHINGTON 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 11 Depertment of Health and Mental Hygiene.

Important: If Item 27 is marked other then "neturel", or items 23s or 2, any injury or other treumatic event, the Medical Examination 2002. 10f. Zip Code 10g. Citizen of What Country? 251 OTHO HOLLAND DRIVE 21795 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 SEAMSTRESS CLOTHING MANUFACTURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN CLAYTON MOSE EMMA GERTRUDE WALLIZER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 55, Zullinger, PA 17272 ANDREA L. RALSTON, DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ST. MARKS CEMETERY 8/19/2006 BOONSBORO, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BAST FUNERAL HOME BOONSBORO, MARYLAND 7606 OLD NATIONAL PIKE 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence or): anding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death signed by the e 5 Other (specify) 9 Unknown 9 Duknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1□ Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Yes 2 No Other: Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1/ Natural 5 Pending investigation Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours efter To the Funeral Dire 1 Certifying Physician: To the hest of my knowledge death occurred at the time. data and place, and due to the dause(s) and mammer as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 06 1060391 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 FAR 10 J 1 5 3H-4 ME 31. Date filed (Montfi, Day, Year) 32. Registrar's Signature State 2006 Registrar

		For State Registrar	State of Maryla		artment of h			Reg. No. UU5	27327
Physic		1. Decedent's Name (First, Middle, Las Betty J. Mort	st)				2. Date of Dea Month August 1	Day Year	3. Time of Death  10:15 P. M
/Med Exam		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	or Location of		4c. County of Deat	
LXaIII	ii iei	63 Sherwood Drive	е		Walkersv	ville		Frederic	ck
Funera Directo		5. Social Security Number 6. Social Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ex □ м 2 <b>x</b> F 7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Da	9. Birt y, Year) 9. Birt Co per 19, 1932	hplace (State or Foreign huntry)  Maryland
death with the Maryland ms 23a or 28a-f ehow rmust be notified at	٥٠	Usual Residence of Decedent  10a. State 10b. County  Maryland Frederic		ity, Town or Lo					10d. Inside City Limits
the N	recto	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
with 3a or	٥	63 Sherwood Drive			2179	93		USA	
<u> </u>	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Marmed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 2 No		n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Ame Black, Whit Specify:	
Lin 72 hours at e. "neture!", or Medical Exam	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most o ad)	of working	16b. Kind of Business	
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Viand build be file Mental Hy arked oth atic even	Be	17. Father's Name (First, Middle, Last)  Maurice Crum					lary Carmac		
hould d Mer marke	2	19a, Informant's Name/Relationship	Type Print)	19b Maili	ng Address (Street	1		er, City or Town, State,	Zip Code)
Mang d 2 st ith and 27 ie n traun		Franklin Mort - h						le, Marylan	
Heal Heal		20a. Method of Disposition		Place of Dispo	sition (Name of matory or other pla	1	Date	20c. Location - City or	
ages ent of nt; if i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐			n Memoria		-16-2006	Frederick	Maryland
baltimore permit. Pages 1 Department of He important; if iten eny injury or oth	Buch	21. Sign were of Funeral Service Licer		DOM:	2. Name and Address		Stautter	Funeral Honderick, Mar	
box 68/60, death certificate be executed  Examine and e attending physicien and od for use as the burial-transit	icai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inifiated events resulting in death) Last	a. Metastovi c  Due to (or as a conse  b. Due to (or as a conse  c. Due to (or as a conse  d	equence of):	Can	Cer			6 m
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	□Ectopic pregnand □ Other (specify) _	су		23d. Date of de Month	livery Day Year
<u> </u>	Ď	Part II. Other significant conditions	confinbuting to death buf not re	esulting in the u	inderlying cause g	iven in Part I.		fobacco use contribute t Yes 2 No 3 □ P	o the cause of death?
The The page	Completed						24a. Was auto perfo 1  Yes	psy prior to death?	ufopsy findings available completion of cause of s
of Vital F Physician: Th rthis certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	(Tep/2		ther	of Death (Check only		
on of ding Phy a. After this funeral d	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju	4   Nur	28d. Describe	idence 6 Other (Spe how injury occurred	ecity)
DIVISION C Prospital or Attending P 24 hours after death. • Funeral Director: After i	Certification:	3 Suicide 6 Could not be determined		home, farm, si	reet, factory, office	Ð		(Street and Number or Fi wn, State)	lural Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier 1 Certifying Pl (Check only 2 Medical Execution)	hysicien: To the best of my k miner: On the basis of exami and manner stated.	nowledge, dea nation and/or i	th occurred at the nvestigation, in my	time, date and opinion, deat	I place, and due to the h occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
To the within 2 To the complet	×	29b. Signature and title of certifier	In mo		29c. Licer	has number $481$	84	29d. Date signed (Mon	oth, Day, Year)
D		36. Name and address of person who Elhamy ESK-ar	ider, MD	501 V	V 7th S	street	Frederic	K, MD S	2170
Regi	State strar	31. Date filed (Month, Day, Year) AUG 1 6	2006 32 Registrar's Sig	mature A	medi				

Please Type or Print in Black Indelible Ink 06-05754 State of Maryland / Department of Health and Mental Hygiene Kevin Michael Mullarkey 2006 27328 Certificate of Death 1- For State Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day August 4, 2006 1155 hrs Kevin Michael Mullarkey **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Harford Havre de Grace 215 South Union Avenue Apartment 6 If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Hours Min Months Davs Director Country) FL1 X M 2 04/24/1958 221-52-7758 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a. State 10b. County Y Yes 2 No or items 23a or 28a-f show must be notified at once, MD Havre De grace Harford permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21078 U.S.A. 215 S. Union Avenue Apt. 6 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 Married 1 Yes 2
If Yes, Give Yeer
or Datest Thk nown 10 Specify: White 1 Yes 2 No specify: 4 v Divorced 3 Widowed ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical is marked other than 21215-0036 Salesman Dentsply tment of Health and Mental Hygiene.

tant: If item 27 is marked other the Med 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Delores Cabalero Be William Mullarkev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD John Collins Circle Dover, DE 19904 William Mullarkey- father 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Removal from State Burial 2 X Cremation 3 Capital Crematory 8/7/2006 Dover, Delaware Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Torbert Funeral Chapel 61 S. Bradford St. Dover, DE 19904 (per DVR) M00841 William Torbert. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** Between Onset and failure. List only one cause on each line. Death Medical Hypertensive cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. and tran. Physician/Medical X AMENDED X UNPENDED physician a perFH 23a PTT 27 perME.o858.8/29/06 TT item#21 Box 68760. 23d. Date of delivery 23c. If yes, outcome of preg IF FEMALE Year 3b. Was decedent pregnant in the Month Ectopic pregnancy Live birth Fetal death ned by the attending detached for use as past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. To the Funeral Director: After this certificate has been signed by tompletely filled in by the funeral director, page 2 should be detach 1 Yes 2 No 3 Probably 4 V Unknown ģ Steatosis of liver Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26. Place of Death (Check only one 25. Was case referred to medical Be Otherexaminer? Residence 6 V Other: Scene Hospital: Nursing Home 5 ER/Outpatient 3 Inpatient 2 ٩ 1 V Yes No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year 27. Manner of Death Certification: 1 X Natura 1 Yes 2 No Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) Suicide Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 5, 2006 O.C.M.E.

6

State Registrar 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD As

Assistant Medical Examiner

State of Maryland / Department of Health and Mental Hygiens Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician AUGUST** 2006 7:30 AM M MILBREY CATHERINE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON HOMEWOOD RETIREMENT CENTER WILLIAMSPORT If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 ☐ M 2 💢 F Vre OCT. 17, 1907 98 Director <u>215-32-1380</u> MARYLAND Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits •how 10a. State ir than "natural", or Itams 23a or 28a-f ehov the Medical Examiner must be nutified at 1 Yes 2 X No WILLIAMSPORT MARYLAND WASHINGTON Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21795 16505 VIRGINIA AVENUE U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. of fled within 72 hours after di Hygiene.

other than "natural", or Itam 1 ⊠Yes 2 □ No WWII If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: þ 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any injury or other treumatic event, space. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ERNEST B OONE NEIKIRK JENNIE AMELIA EASTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 19a, Informant's Name/Relationship (Type, Print) FUNERAL HOME RECORDS 7606 Old National Pike, Boonsboro, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town. State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Denation 5 Other (S sally) BOONSBORO CEMETERY 08/23/2006 BOONSBORO, MARYLAND 21. Signature of Fundal Service Cicens 22. Name and Address of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Part . Enter the disease or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a con Examiner HEAUCCLUNG" Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last u to (or as a consequence of): attending physicien and for use es the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown þ Other significant conditions confutbuting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď X6att OCK 2 N No 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificete 20 No 1 Yes Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 3 DOA this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending 1 TYes 2 No investigation after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signaty 29d. Date signed (Month, Day, Year) 29c. License number 2006 MEDICON noan (son who completed cause of death (Item 23a) Name and address of WH5+1 (611) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

		•	For State Registrar		State of Ma	aryland / De	partment <i>ertificate</i>	of He of D	ealth and Death	Mental H	ygien Reg. N	200	16	27330
	Physici			ne (First, Middle, Last) <b>LICE M</b>		ARKER				2. Date of D Month Augu		ay 25 3	Year 2000	3. Time of Death
	/Medic Examin Funeral Director		Manc 5. Social Security P 228-48-52	1 6. Sex	anor	a (In yrs. last birthda <b>7</b> Yrs.	Pris	∩ C €	SS A If Under 24 Hrs Hours Min.	nne. 8. Date of B	lirth Dav. Yea	c. County of So	9. Birthp	rSet
	land bw		Usual Residence of 10a. State	10b. County		10c. City, Town or	Location						1	0d. Inside City Limits
	Marylan a-f ehow	tor	MD	Somerset		Princess	Anne							Yes 2□No
	ith the	Director	10e. Street and Nu	imber			10f. Zip (	Code			10g. C	Citizen of W	hat Cour	ntry?
	s 23a	rail		gehill Ter		Toronto II C	218		i- Oriela 2 /6	Sandy Manage	USA		Amaria	an Indian
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28s-f ehow or other traumatic event, the Medical Exabilizational be multified at	d by Funeral	11. Marital Status  1 Never Mar  3 Widowed	ried 2 Married	12. Was Decedent If Armed Forces? 1 Tyes 2 The If Yes, Give Year or Dates:		If Yes, specing		panic Origin? (S , Mexican, Puer Specify:	to Rican, etc.)	NO-	Black	White,	
5-0	natu	etec	(Ѕрв	15. Decedent's Educify only highest grade		(Gi	cedent's Usual ve kind of work b. DO NOT use	done du	tion uring most of wo	rking	16b.	Kind of Bu	siness/In	dustry
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	other	O I		(First, Middle, Last)					18. Mother's Na	me (First, Midd			3)	
ylar	12 should be filed within h and Mental Hygiene. 7 is marked other than * traumatic event, the Men	To B		d B. Mapp,						Virgini		<u>-</u>		
, Maryland	1 and 2 sho Health and tam 27 is m			lame/Relationship <i>(Ty<sub>i</sub></i> d A. Tarr	-		_		Pungot					_
Baltimore,	Pa mer ury			Sposition  Cremation 3 P  5 Other (Specify)	emoval from State	20b. Place of Dis comptery, c Occohani Cremator	nock nock ry, Inc	ner place	0,2	Date 8/2006	Exm	Location - (		
Ball	permit Pa Deparmen Important: any injury once.		21. Signature 1 F	unsul Service Licens	englit	7	Dough P.O.	Address Ly F Box	uneral 633, Ex	Home, I more, V	nc. irgi	nia 2	3350	
*	Ú.	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respect, or heart failure. List only one cause on each line.												Approximate Interval Between
	Physician		Immediate Cause disease or conditi resulting in death)	on	l.:	BCUD								Onset and Death
2	/Medical Examiner		rosulting in docum	ſ	Due to (or as	e consequence of):	Failyn							
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,09	icate be executed physicien and s the burial-transit	ai Ex	resulting in death)	Last	Due to (or as	a consequence of):								
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	tuires that the de n signed by the e uld be detached t	2	Part II. Other sign	ificant conditions con	tributing to death bi	ut not resulting in the	underlying ca	use giver	n in Part I.	1				ne cause of death? ably 4 Unknown
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of Vital	ding Physician: The h. After this certificate hi funeral director, page	Be	25. Was case refe examiner?	/					26. Place of De					
of	Physi this c	<u>۲</u>	1 ☐ Yes 2 ☐ 27. Manner of Dea	INO	ospital: 1  Inpatie 28a. Date of Injur				4 Nursing I	Home 5 ☐ Re				1)
on	th. : After s funera	ation	1 Natural	5 Pending investigation	(Month, Day	Year) Injur	y M	lc. Injury Work: 1 🔲 Y	es 2 □No	200. Describe	3 11044 1113	dry occurre	, d	
Division	i i i i	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injubulding, etc	rry - At home, farm, c. (Specify)	street, factory,	office			(Street a own, Sta		or Rura	I Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edicai (	29a. Certifier (Check only one)	1 Certifying Phys 2 Medical Examin	sician: To the best of nar: On the basis of and manner sta	examination and/or	ath occurred a investigation,	t the time in my opi	e, date and place inion, death occ	e, and due to th urred at the time	e cause( e, date a	s) and mar	ner as st	ated. the cause(s)
	To the To the Comp	Me	29b. Signature and					License				ate signed		Dey, Year)
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<u>Carro</u>	3		30. Name and add	ress of person who co	mpleted cause of d		e, Print)	54	094 45BL AU	ND	21	804		
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ORIGINAL

Tar Parker

State of Maryland / Department of Health and Mental Hygienes 27331 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 0355 AM 2006 Clara Poe Pennington A-405+ 23 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** (ccil of Union Hospital Cov-+7 (etc) ElKton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG 7, 1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1□M 27 F North Carolina 88 222-18-3221 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "neturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Ceci1 E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 107 Creswell Avenue 21921 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ۾ 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "ne eny injury or other treumatic event, The Madle 2006. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Supervisor Mushroom Cannery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ellis Poe Ella Bare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda J. Marquess/Daughter 107 Creswell Avenue, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 26. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkton Cemetery 2006 Elkton, Maryland P.A. Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee Approximate fnterval Setween Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final Carcinoma 3 broughles Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner s been signed by the attending physicien and should be detached for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificete has 2 No 1 Yes 2 No 1 Yes To the Hospital or Attending Physicien: within 24 hours after death.
To the Funeral Director: After this certifice : After this certification tuneral director. 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 🗌 Yes 2 No 1. Pripatient 2 ER/Outpatient 3E DOA 28c. Injury at Work? ate of Injury (Month, Day Year) 27. Manper of Duath 28b. Time of 28d. Describe how injury occurred 1 Matural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) -4 Homicide 29a. Certifier 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1005/190 30. Name and Iddress of person who completed cause of death (ftem 23a) (Type, Print) Elkton MD 106 31. Date filed (Month, Day, Year) 32. egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registrar		State	of Marylar	nd / Depa <i>Cer</i>	irtment of tificate of	Health Deat	n and M th	lental Hygi	ene2	006	27332
	Physici		1. Decedent's Name ( Betty	First, Middle	, Last)		Rankir	1			2. Date of Death August	_	200 <sup>6</sup> ar	3. Time of Death 4:50 PM
	/Medic Examin		4a. Facility Name (If n			umber)		4b. City, Town,	_	on of Death			unty of Death	1
7	Funeral	- 12	Citizens 5. Social Security Nun 365-16-813	nber	1 <b>g Home</b> 6. Sex 1 □ M 2 <b>X</b> F	7. Age (In yrs.	. last birthday) Yrs.	Freder If Under 1 Yea Months Day	r If Und	der 24 Hrs.	8. Date of Birth (Month, Day,	Year)	Coun	lace (State or Foreign
3	Director		Usual Residence of D		- A						Jan 25,1	919	Michi	lgan
	ehow	ū		Ob. County  Frede	rick		ity, Town or Lo ederick	cation					1	0d. Inside City Limits 1 ☐ Yes 2 No
	r 28a-f	Director	10e. Street and Numb		LICK	110	COLICA	10f. Zip Code			10	g. Citizen	of What Coun	
	23a o		5955 Quin	n Orch	ard Raod			21704	4			U	ISA	
036	urs after des al', or Iteme Exeminer m	by Funerai	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4		Armed F	2 <b>▼</b> No	11	Vas Decedent of Yes, specify Cu ☐ Yes 21 N	ban, Mexi	can, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify: Wh	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mentall bygiene.  Important: If tiem 27 is marked other than "natural", or iteme 23a or 28a-f ehow important: If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow eny injury or other traumatic event, the Medical Exerciper must be notified at once.	Completed	(Specify Elementary/Second		t grade completed	(1-4or 5+)	(Give	ent's Usual Occ kind of work don OO NOT use retii	e during m ed)	nost of work	ing		of Business/Ind	dustry
Maryland 2	ld be filed lental Hygie ked other Ic event, II	To Be Co	17. Father's Name (F)	irst, Middle, I	.ast) Beute	<b>r</b>	<u> </u>		18. Mc	other's Name	e (First, Middle, M		mame)	
lary	2 shou and M Is mar		19a. Informant's Nam		ip (Type, Print)			•	et and Nur	mber or Run	al Route Number,	City or To	wn, State, Zip	Code)
ē,	1 and Heelth tem 27 other ti		Robert R.  20a. Method of Dispo		n/Son	20b.	Place of Dispos	sition (Name of		_	erick, M		02 on - City or To	wn, State
altimore,	Pages nent of ant: If i		1 ☐ Burial 2 🕱 4 ☐ Donation 5		3 □Removal from secify)	n State		natory or other p	,	8/16	/2006 F	rede	rick, M	D
Balt	Departi Departi Importa eny Inje		21. Signatore of Force	eral Service I	icensee		22 1	Name and Add	ress of Fa SSUMT	own St	auffer F ike, Fre	unera deric	1 Home	217 <del>0</del> 2
8760,	Cate be executed which is the burial-transit the bu	dicai Examiner	23a. Part. Enterne show, or heart Immediate Cause (Fi disease or condition resulting in death)  Sequentially list condition if any, leading to immediate. Enter Underly Cause (Disease or in that initiated events resulting in death) La	nal nediate ring jury	a. Due to	caused the deal pach line.  Any C to or as a conserve or (or a))).	quence of):	Lews 1	20,	Scarolac d	or respiratory arre	st,		Approximate Interval Between Onset and Death
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	w requires that been signed b should be deta	þ	Part II. Other signific	ant conditio	ns contributing to	death but not re	sulting in the ur	nderlying cause o	given in Pa	art J.	23e. Did tob	1		e cause of death? ably 4 ⊟Unknown
tal Records,	yeicien: The law re is certificete has bed director, page 2 sho	e Completed	25. Was case referre	d to medical					ae Di	and of Door	24a. Was ar autops, perform 1 Yes 2	ed? No	4b. Were auto prior to cor death? 1 \(\sum \text{Yes}\)	psy findings available inpletion of cause of 2 No
Division of Vital	Attending Physicien: The law requires that the croading Physicien: The law redail.  actor After this certificate has been signed by the the funeral director, page 2 should be detached the funeral director.	ation: To Be	examiner? 1  Yes 2 No.  27. Manner of Death 1  Natural 2  Accident	5 Pendin	28a. Date (Mo	Inpatient 2[ e of Injury enth, Day Year)	28b. Time of Infury	28c. In	ther:	Nursing Ho	me 5 Reside	nce 6		()
Divis	를 를 들 드	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could r	ned 286. Place	ce of Injury - At I ding, etc. <i>(Spec</i>	ify)				28f. Location (Str City or Town	State)		
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 (Check only 2: one)	Certifyin Medical	g Physician: To the Examiner: On the and ma	ne best of my kn basis of examin	owledge, death ation and/or inv	occurred at the restigation, in my	time, date opinion, o	and place, death occur	and due to the ca red at the time, da	use(s) and ite and pla	d manner as st	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and the	ete of Pertifier	012	1		29c. Lice	nse numb	er	29	d. Date si	gned (Month,	Day, Year)
}			197	Afor	- Kan	hu	/	2	-/3	971		8/	16/0	6
	10		30. Name and addres					Print) • Frede	riol-	MD 2	1701			ASSE
	Sta Registi		31. Date filed (Month)		6 2006	Redistrar's Sign	nature	food	وخلط		I.MI			

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Thomas Elwood SPIELMAN August 14, 2006 10:35 a. M /Medical 4a. Facility Name (If not institution, give street and number) VIIIage at Robinwood 19800 Tranquility Circle 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year)
June 8, 1911 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F Mary land 95 Yrs. 214-09-1961 Director Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or iteme 23s or 28e-f ehow the Medical Examiner must be notified at 1 Yes 2 No Washington Maryland Hagerstown Directo 10e. Street and Number Village at Robinwood 10f. Zip Code 10g. Citizen of What Country? 19800 Tranquility Circle 21742 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No ff Yes, Give Year or Dates: WW I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. white WW II Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done d life. DO NOT use retired) during most of working al Hygiene. Colfege (1-4or 5+) Efementary/Secondary (0-12) sign painter/illustrator federal government 12 permit. Pages 1 end 2 should be filed.
Department of Health and Mental Hyg important: if item 27 is marked other eny injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas E. Spielman Alice M. Perrin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roscoe G. Spielman - son 2302 Riverview Dr., Murfreesboro, TN 37129 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 8/17/06 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Cardio vosaden desiase Altreoscloritu 3 weeks /Medical Due to (or as a consequence of): Examiner 4 mails Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical *fF FEMALE* 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? detached for Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 å 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Pface of Death (Check only one) Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 Yes 2 No 3□ DOA this 28a. Date of fnjury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred Naturaf Naturaf 5 Pending within 24 hours efter death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide (Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Manyeri D28365 8-16-06 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) H-20+ Street Heys Former MD21740 ANZ AR HAP1 368 16 2006 31. Date filed (Month, State AUG Registrar

DHMH 17 Rev 1/2001

		1	For State Registrar	State of Maryland		rtment of H tificate of L			2006	27334
	Dhysiair	2	1. Decedent's Name (First, Middle, Last)	ub. Jr.				Date of Death Month	Day Year	3. Time of Death
3.5	Physicia /Medic	al -				4h City Town or	Location of Death	August 1	4, 2006 4c. County of Dea	11:40 P M
	Examin	er	sa. Facility Name (If not institution, give st 9220 Baltimore Nat			Middle			Freder	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, ) Oct • 13,	9. Bir 1956 Ma	thplace (State or Foreign Duntay) ryland
	Du &	-	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	eation				10d. Inside City Limits
	Maryta f eho	_	Maryland Frederic	k	Mi	ddletown				1 ☐ Yes 2X☐ No
	r 28a-	<b>♀</b> ⊢	10e. Street and Number			10f. Zip Code			g. Citizen of What Co	
	ath wit	raiD	9220 Baltimore Na			217			United St	
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It Item 27 is marked other than "natural", or items 23a or 28a-f ehow or other treumatic event, it is Medical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 ANO If Yes, Give Year or Dates:		Vas Decedent of H	ispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	
2-0	72 hou		15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occup	during most of worki		6b. Kind of Business	/Industry
21215-0036	within then then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired Truck Dri	•		Trans	portation
and 2	12 should be filed within and Mental Hygiene. Fis marked other than "reumatic event, its Me.	Be	17. Father's Name (First, Middle, Last) Calvin M. Staub,	Sr.			18. Mother's Name Kitty Sp		aiden Sumame)	
Maryland	nd 2 should th and Me 27 is mark treumation	<b>1</b> 0	19a. Informant's Name/Relationship (Type Denise Staub / Wif	e, Print)	19b. Mailin 9220	g Address (Street Baltimor	and Number or Rura e Nationa	al Route Number,	City or Town, State, Middletow	Zip Code) n, MD 21769
Baltimore,	Pages 1 and 2 ent of Health nt: # Item 27 i		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	ce ce	metery, crer	sition (Name of natory or other place Church Ce	em. 8/18	3/2006 M		, Maryland
Baltii	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		21. Sign yer of Funeral Service License	milles			ssumtown	Pike, Fre	Funeral Ho ederick, N	
			23a Part1. Enter the disease, or complic shock, or heart fallere. List only on	eations that caused the death.	. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Nonsmall	cell	1	cancer			Criset and Death
	/Medical Examiner	3	resulting in death)	Due to (or as a consequ	ence of):	J				
i i	Sec. 1	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):					
	be executed sicien and burial-transit	Examine	Cause. (Disease or injury that initiated events resulting in death) Last							
8760,	be exe cien a burial-	al Ex	resulting in death) Last	Due to (or as a consequ	ence or):					
687	ficate physics the	edicai	<b>\</b> d							
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3[	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	alivery Day Year
<u>α</u>	uires that t signed by id be detai	þ	Part II. Other significant conditions con	tributing to death but not resu	ilting in the u	nderlying cause giv	ven in Part I.			to the cause of death?  Probably 4  Unknown
of Vital Records,	The law requir	Completed						24a. Was ar autopsy perform	prior to	
ital		Be C	25. Was case referred to medical examiner?				26. Place of Deal	th Check only one		
× ×	S O	은	1 ☐ Yes 2 No		ER/Outpatie	IL 30 DOA			nce 6 Other (Sp	ecify)
	ding Afte fune	ion:	27. Manner of Death  1. SNatural 5 Pending 2. Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	ryat rk? ]Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	or Attendi after death. Director: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st	reet, factory, office		28f. Location (Str City or Town	eet and Number or I , State)	Rural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai C	29a. Certifier (Check only one) Certifying Physical Examination	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, deat tion and/or in	h occurred at the to exestigation, in my	ime, date and place, opinion, death occur	and due to the ca rred at the time, da	use(s) and manner ate and place, and de	as stated. ue to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	)		29c. Licen	2/1/21	29	d. Date signed (Mo	nth, Day, Year)
	$\mathcal{O}_{I}$		30. Hame and whees of person who co	mpleted cause of death (Item	23a) (Type	Print)	3642(	V Fr. I	= 1 M	12006
88	1.		James Hmes	32. Segistrar's Signa	5 K10	geticld	111 10	Y Frede	11014,111	41101
ė	St Regist	ate rar	31. Date filed (Month Pax Year) 20	00	K A	mark!				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death AUGUST **Physician** EDWARD JOHN 14, 10:45AM 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 MM 2□ F Apr. 111 1941 165-32-0116 Pennsylvania Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits il Hygiene. other than "natural", or itema 23a or 28a-f show vent, the Modical Examiner must be cicilified at 1 ☐ Yes 2 No NewMarket Director Frederick Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Coldstream Drive United States 6660 21774 death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Ayes 2 No If Yes, Give Year or Dates: /96/-1969 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0·12) Computers Engineer 4 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) David Shuey Harriet Bucks 19a. Informant's Name/Relations ip (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Shuey/Wife 6660 Coldstream Drive New Market, MD 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 16, 4 Donation 5 Other (Specify)

Resthaven Crematory 2006 Frederic Moryland

21. Signature of Funeral Services Licensee

22. Name and Address & Facility
Resthaven Funeral Services Skkot Cody P. A.
4501 Catoctin Mtn. Hwy. Frederick MD 121701

23a. Part. Enter the disease, or complications to rused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate Interval Behavior Immediate Cause (Final disease or condition resulting in death) DISSEMINATED INTRAVASCULAR COAGULATION Physician 1 WEEK /Medical Examiner CHOLANGIO CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner or Attending Physicisn: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 4☐Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ✓ Inpatient 2 □ ER/Outpatient 3 □ DOA 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) After the 28c. Injury at Work? Certification: 27. Manner of eath 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours efter death. To the Funers! Director: Al completely filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one)

State Registrar

HVA

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and ad so of person who completed cause of death (Item 23a) (Type, Print)

O'CONNOR MD

29c. License number

SOI W, SEVENTH ST.

131761

29d. Date signed (Month, Day, Year)

			1- For Amend Item 23 4 per Mary aggi	58 <b>,08/29706dh</b> Certificate of	dealth and Mental Hy <i>Death</i>	rgien 2006	27336
	Physici	an	Decedent's Name (First, Middle, Last)     DENNIS WAYN	e coecum	2. Date of De Month	Day Year	3. Time of Death
	/Media	al			August	21 2006	7:21 A M
	Examir	er	4a. Facility Name (If not institution, give street and number)  Kline Hospice House	Mount A	or Location of Death	4c. County of Death Frederick	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday) If Under 1 Year	If Under 24 Hrs. 8. Date of Bi		place (State or Foreign
	Director		214-66-6442 1 1 M 2 F 52	2 Yrs. Months Days	Hours Min. (Month, D. Mar. 3	, 1954 Mar	yland
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Location			10d. Inside City Limits
	Mary First	tor	Maryland Frederick County Fred	derick			1 ☐ Yes 2X No
	or 288	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Cou	•
	ath wi		6394 Overbrook Circle	2170		United State	
39	d within 72 hours after death with the Maryland jiene. I then "neturel", or items 23e or 28e-f show the Medical Evacinet must be multified at	by Funeral	11. Marital Status  1 Marital Status  1 Marital Status  1 Marital Status  1 Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 M No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Specify Yes or No nan, Mexican, Puerto Rican, etc.)  Specify:	o- 14. Race - Ameri Black, White, Specify: Whi	etc.
21215-0036	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occu	pation during most of working	16b. Kind of Business/Ir	ndustry
2	within ene. then "	mpie	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retire Worker	during most of working d)	special nee	eds workshor
g 5	be filed v tal Hygie d other t event, to		U 17. Father's Name (First, Middle, Last)	WOLKEI	18. Mother's Name (First, Middle	<u> </u>	<u>-</u>
Maryland	be de la la la la la la la la la la la la la	To Be	William Clyde Specht		Hilda Irene	Stine	
<u>a</u>	and and sum	-	19a. Informant's Name/Relationship (Type, Print)		and Number or Rural Route Numb		
	s 1 and 2 f Health item 27 other tra		Carolyn Abrecht / sister	314 Avalon I		ster, Marylan	
Soc.	of of		1 Burial 2 ☐ Cremation 3 ☐ Removal from State	ce of Disposition (Name of netery, crematory or other place Church C	of the Aug. 24	20c. Location - City or T	
Baltimore,				hren Cemetery 22. Name and Addin	2006	Rocky Ridge	e, Maryrand
Ba	permil. Departr imports any inju		Alan C. Turvis		Baltimore Street	neral Home : Taneytown,	Md. 21787
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not enter the mode of dy	ng, such as cardiac or respiratory a		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Aspii	ration Pneumonia		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence)				4 years
		P.	Sequentially list conditions, if any, leading to immediate b. Due to (a as a conseque	-//	provascular Accie sclerotic Vascula		3 August
	uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	resenter 6	Collins.	ar bisease	15 years
o,	sician and burial-transit		resulting in death) Last Due to (or as a conseque	nce of):		)	
8760,	cate be executed bhysician and the burial-transit	dicai	Ca Adtrio	selvatic	Vommen A	seeme ?	Syse
. Box 6	ath certifications attending processes as	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown   Unkn	eath 3 Ectopic pregnance	у	23d. Date of deliv Month	ery Day Year
P.0	that the de led by the a detached		Part II. Other significant conditions contributing to death but not result	ing in the underlying cause gr	ven in Part I. 23e. Did	tobacco use contribute to t	he cause of death?
Records,	quires n sign	ed by	Downs Syndrome		1 🗆	Yes 2 No 3 Prol	oably 4 Unknown
000	aw requir is been si 2 should	Completed			24a. Was		ppsy findings available
ž		Com			auto perfe 1 □ Yes	ormed? death? 2 ☑ No 1 ☐ Yes	mpletion of cause of 2□ No
Viital	i ii	Be (	25. Was case referred to medical examiner?		26. Place of Death (Check only	one)	
of		To		Voutpatient 3 DOA	her: 4 Nursing Home 5 Res	idence 6 <b>X</b> Other (Special how injury occurred	
	Attending I or death. ector: After by the funer	itlon	1 X Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury Wo	rk?  Yes 2 \ No	now injury occurred	Facility
Division	l or Attendi after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office		(Street and Number or Run wn, State)	al Route Number,
	itel or irs afte rel Dir led in	Cert					
	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by tt	edicai	29a. Certifier  (Check only one)  2 Medicel Exeminer: On the basis of examination and manner stated.	edge, death occurred at the tin and/or investigation, in my	me, date and place, and due to the opinion, death occurred at the time,	cause(s) and manner as s , date and place, and due to	stated. o the cause(s)
	o the o the omple	Med	and marrier stated.	29c. Licen.	se number	29d. Date signed (Month,	Day, Year)
)	⊢≯⊢ŏ		29b. Signatur and title of certifier	no 525	742	8/22/20	06
	7.1		30. Name an Address of person who completed cause of death (Item 2			otrater	V 6
	7			688 Poole Roa	d Westmi	nster, Md. 2	1157
	Sta Registi		31. Date filed (Month, Day, Year)  AUG 2 9 2006  32. Registrer's Signar	aske)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006. 27337 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Mary Trumpower 23 August 2006 1:15 P. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Williamsport Nursing Home Williamsport Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖺 F 92 216-09-0950 Director May 11 1914 Maryland Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Iteme 23a or 28e-f show the Madical Examiner must be notified at 1 ☐ Yes 2 No MD. Washington Director Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Fleming Dr. APt. B 21750 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: Be Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembler Aircraft Mfg. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any Inlury or other treumatic event size. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Amos J. Gearhart Grace V. Lefever 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vickie Lee Quackenbos/Daughter P.O. Box 338 Hancock, Md. 21750 20b. Place of Disposition (Name of cometery, crematory or other place Parklawns Memorial Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/26/06 Chambersburg, Pa. 4 ☐ Donation 5 ☐ Other (Specify) Gardens 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tailure 2 weeks renal /Medical Due to (or as a consequence of): Examiner 3 weeks difficile colitis with lostridium Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Completed by Physician/Medical Examiner bleeding gastrointestinal physicien and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 1 € 10 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Mellitus 24b. Were autopsy findings available prior to completion of cause of death? Aortic Stenosis 24a. Was an autopsy 2 🗆 No Congestive 25. Was careferred to medical Heart failure 1 ☐ Yes 2 1 No 1 TYes or Attending Physician: Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Natural To the needs often death.

Within 24 hours efter death.

To the Funeral Director: Aft death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47451 august 24, 2006 Cynthia Kuttney - Sands, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

AUG 2 9 2006

Cynthia Kuttner-Sands, MD. 154 North Artizan Street,

32. Higistrar's Signature

Williamsport, Maryland

State of Maryland / Department of Health and Mental Hygiene 2006 27338

	1 - State Registrar	Cer	tificate of De	eath	Reg.	No.	
	1. Decedent's Name (First, Middle, Last)			2.	Date of Death	Day Your	3. Time of Death
Physician /Medical	- MIRIAM WALREDT HELLIAM			A		Day Year 13 2006	1:05 AM
Examiner	A = 100 At - 200 At - 100 At -	number)	4b. City, Town, or Lo	cation of Death		4c. County of Death	
	2200 CHESTER ROAD		CHESTER			QUEEN ANNE	e's
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		Under 24 Hrs. 8.	Date of Birth (Month, Day, Ye		place (State or Foreign ntry)
Director	217-07-9530	93 Yrs.	Midrial Days	0	6/07/191	3 MD	
pu s	Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or Lo	cation				10d. Inside City Limits
aho aho	,		Cation				1 ☐ Yes 2 X No
vith the Maryland to 28a-f show be notified at	MD QUEEN ANNE 'S	CHESTER	104 7:- Code		10-	Citizen of Miles Cour	
with a or i	2000 OFFICIENT POAR		10f. Zip Code			Citizen of What Cou	ntry?
after death with the Maryland after death with the Maryland or Items 23s or 28s-f show miner must be notified at VEuneral Director	2200 CHESTER ROAD  11. Marital Status 12. Was D	Pecedent Ever in U.S. 13. V	21619 Was Decedent of Hispa	anic Origin? (Specifi	USA v Ves or No.	14. Race - Ameri	can Indian
ter d	1 Never Married 2 Married 1 Ye	Forces?	f Yes, specify Cuban, I	Mexican, Puerto Ric	an, etc.)	Black, White,	
	3 X Widowed 4 □ Divorced If Yes,		1 ☐ Yes 2 <b>X</b> No S	Specify:		Specify: WH	IITE
A LA LO-UUCS ed within 72 hours ygiene. ner then "natural; t, the Medical Exe	15. Decedent's Education	16a. Deced	lent's Usual Occupatio	on	16b	. Kind of Business/Ir	
within 7 wit	(Specify only highest grade complete Elementary/Secondary (0-12) Cofleg	e (1-4or 5+)	kind of work done duri OO NOT use retired)	ing most or working			
	10	ROMEM	AKER		OV	N HOME	
D EITS E			18	3. Mother's Name (F	First, Middle, Maid	den Sumame)	
should be not Menta in marked umatic av			C	LARA BIGG	S		
20 20 20 20	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ig Address (Street and	Number or Rural R	loute Number, Cit	ty or Town, State, Zip	Code)
and and n 27	NORMA PATTON / DAUGHTE		CHESTER RO	AD, CHEST	ER, MD 2	21619	
es 1 a of Hee	20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other place)	Date	20c	. Location - City or To	own, State
antimor	*4 □Donation 5 □Other (Specify)		LLE CEMETE	RY 08/16/	2006 ST	EVENSVILL	E. MD
DEBILLIMO permit. Pages Department of Important: If i any injury or once.	21. S'an ature of Juneral Service Licensee	/97/ PE	. Name and Address of	of Facility FENRETN &	NEWNAM	FIINERAL H	OMF PA
n abesa	Chf 14 41		LLOWS, HEL 6 SHAMROCK			21619	
* * *	23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do not enter each line.	er the mode of dying, s	such as cardiac or re	espiratory arrest,		Approximate Interval Between
Physician	Immediate Cause (Final disease or condition	Calon	~ cor	- Inoma			Onset and Death
/Medical Examiner	resulting in death)  Due	to (or as a consequence of):					
X	Sequentially fist conditions, b.						
si ed	cause. Enter Underlying	to (or as a consequence of).				- 1	
executed on and lateransit	Cause (Disease or injury that initiated events resulting in death) Last Due	to (or as a consequence of):					
cien cien ourial		to (or as a consequence or).					
X 08/00, certificate be ex- ding physicien se as the burla ////////////////////////////////////	d						
ocarificate be executed training physicien and use as the burial-transit	IF FEMALE: 23c If yes	outcome of pregnancy				221 5	
death death e atten	23b. Was decedent pregnant in the past 12 months?	re birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of deliver	ery Day Year
T.O. DO	1 ☐ Yes 2 ☑ № 9 ☐ Unknown 9 ☐ Ur	nknown	Curior (Specify)				
		o death but not resulting in the ur	nderlying cause given it	n Part I.	23e. Did tobaco	co use contribute to t	he cause of death?
d by d by d by d by					1 🗆 Yes	Ż⊠No 3□Prot	pably 4 DUnknown
MECOTOS The law requires te has been sign age 2 should be					24a. Was an	24h Wass sute	and findings available
D a S S	1				autopsy performed	prior to co	psy findings available mpletion of cause of
					1□ Yes 2X	No 1 ☐ Yes	2 No
VITAL sicien: T scertificat irrector, pi	examiner? Hospital:		Othor	5. Place of Death (C			
Phy rathis	1 163 23 40	☐ Inpatient 2 ☐ ER/Outpatien  Ite of Injury 28b. Time of	3 DOA		5 A Residence	6 Other (Special	γ)
ding ding h. Alte tune	1 Natural 5 Pending (A	te of Injury 28b. Time of Injury Injury	28c. Injury at Work? M 1 ☐ Yes	2 □No		nary coournes	
r Attending or death. rector: Alte by the fune tification	3 Suicide 6 Could not be determined	ace of Injury - At home, farm, stre			Location (Street	and Number or Rura	Il Route Number.
DIVISION of tall or Attending P is after death. all Director: After ted in by the funeraction: Certification:	4 Homicide determined bu	ilding, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town, St	ate)	,
spits hours meral y fille.		the best of my knowledge, death	occurred at the time,	date and place, and	due to the cause	e(s) and manner as s	tated.
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.  Medical Certification: To Be C	(Check only 2 Medical Examiner: On the and m	e basis of examination and/or invitance stated.	estigation, in my opinio	on, death occurred a	at the time, date a	and place, and due to	the cause(s)
To the within To the comp	29b. Signature and title of certifier		29c. License nu	umber	29d.	Date signed (Month,	Day, Year)
	1 May Shew	Cum	037	136	5	114/116	6
	30. Name and address of person who completed c	ause of death (Item 23a) (Type, I	Print)	^			
	Coy J Sprane	- 2/UPD.	poruho	Drive	Chip	~ MJ 2	1419
State		Registrar's Signature	lanka.				/
Registrar	AUG 1 5 2006	Julian St 1	734L				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2006 27339 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:25 P <sup>M</sup> August 12, 2006 Wood Pearl Violet /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1□M 2\ F Yrs. 86 Virginia Director 577-16-6119 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene and the Hars 23 ev 28 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 🔀 No **Funeral Director** Lothian Arundel MD Anne 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 20711 100 4th Street 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed by white 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) grocery store retail and bakery manager 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Fletcher Boley George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3712 Idolstone Lane, Bowie, MD 20715 Mary V. Moore, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of H
Important: if Ite
any injury or of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National 08-18-2006 Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE for use a 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1□ Yes 2Ū No 1 TYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 2 No 1 Unpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Fames 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) motanes ATU 32. Registras Signature 31. Date filed (Month, Day, Year) State AUG 1 6 2006 Registrar

			1 - State of Maryland / De	partment of Health and Nertificate of Death		en 2006	27340
	F.		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Robert Wayne Wright, Sr.		August	11, 2006	5:13 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Calvert Memorial Hospital	Prince Frederick  avi If Under 1 Year   If Under 24 Hrs.	,	Calvert C	
	Funeral Director		5. Social Security Number $4.10-42-0246$ 6. Sex $1 \boxtimes M$ 2 $\square$ F 75 Yrs	Months Days Hours Min	(Month, Day,	Year) Cou	nplace (State or Foreign untry) <b>NESSEE</b>
			Usual Residence of Decedent		ren. 19	1331 1611	nessee
-	how tal	_	10a. State 10b. County 10c. City, Town o	r Location			10d. Inside City Limits 1 ☐ Yes 2 No
	8a-fs	cto	MD Anne Arundel Co. Lothian		· · · · · · · · · · · · · · · · · · ·		
	a or 2	吉	10e. Street and Number  187 B Court	10f. Zip Code 20711	10	ig. Citizen of What Cou	untry?
	ns 23	Funeral Director		3. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	ncan Indian,
0	or iter		Armed Forces? 1 □ Never Married 2 □ Married 1 X Yes 2 □ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
2000	irai', c	d by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 █ No Specify:		Specify: Wh	.r.e
ה ו	natu	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	acedent's Usual Occupation live kind of work done during most of work e. DO NOT use retired)	ring 1	l6b. Kind of Business/l	ndustry
<u> </u>	than	duc	Elementary/Secondary (0-12)   College (1-4or 5+)	ectrician	+	Electrical	Company
5	Hygi other	Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, M		Canpain
yland	Aenta Aenta rked tic ev	To B	James H. Wright	Lucille	Bean		
Mary	permit. Pages 1 and 2 should be lied within 72 hours after usern with the maryland Department of Health and Mental Hygiene. Informatical if it is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at once.		19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Rui	al Route Number,	City or Town, State, Z.	ip Code)
າ ≤	and lealth m 27 her tr		Michael S. Wright (Son) 110	4 Parkington Lane.		aryland 20	716
	iges not the first of the or of		I Dunai Za Cienation 3 Dinemovaliron State		130 ±0,	Oc. Location - City or 1	
altimor	nt. Fa		*4 □Donation 5 □Other (Specify) Lee Cr	ematory 2  22. Name and Address of Facility Le		Clinton, M 1 Home Cal	
0	Depa Impo any ir			8125 Southern Maryl			
г			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heert failure. List only one cause on each line.				Approximate Interval Between
4	กงร์เต่อก		Immediate Cause (Final disease or condition	IVE HEART	FA	ILURE	Onset and Death
	/Medical		resulting in death)  a. Due to (or as a consequence of):	000	1		0
	Examiner		Sequentially list conditions, b. CORON	ARY ARTE	27 0	1126436	
	nsit	nine	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
,	al-train	Examin	that initiated events c				
0/00	certificate be executed adding physician and use as the burial-transit	dlcall	d				
0	ng ph	0	IF FEMALE:				
o i	ures that the death certifi signed by the attending I d be detached for use as	Physician/M	23b. Was decedent pregnant  1 Live birth 2 Fetal death	3 Ectopic pregnancy		23d. Date of deli-	very Day Year
5	ne death the atter thed for u	ysic	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)			23,
7	ine law requires that the ste has been signed by th page 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
S	quires n sign ald be	d by	Chrenic Renal Fair	lone	1 🗆 Ye	s 2 No 3 Pro	obably 4 Unknown
ecords	aw requires s been si 2 should l	Completed	Insulin Dependent Di	aloels Mellily	24a. Was an		opsy findings available
ב ב	sician: The law s certificate has t lirector, page 2 s	mo			autopsy perform	led? death?	ompletion of cause of 2 ☐ No
	artifica ctor. Y	Be C	25. Was case referred to dical examiner?	26. Place of Deat	h (Check only one		
> i	rnysician: this certific ral director,	2	1 ☐ Yes 2 ☐ No Hospital: 1 I npatient 2 ☐ ER/Outpa			nce 6 Other (Spec	ify)
	tending Physician: The feath.  tor: After this certificate h. the funeral director, bage	ion:	27. M oner Geath 1 atural 5 □ Pending 28a. Date of Injury (Month, Day Year) Inju	e of 28c. Injury at ry Work? M 1 ☐ Yes 2 ☐ No	28d. Describe hor	w injury occurred	
UNISION	death death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm		28f. Location (Str.	eet and Number or Rui	ral Route Number,
	after after Dire d in b	Certification:	4 Homicide determined building, etc. (Specify)	,, ,, ,	City or Town,		
:	lo the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/c	eath occurred at the time, date and place,	and due to the ca	use(s) and manner as	stated.
	the H the F the F	<b>Aedical</b>	one) and manner stated.				
ì	T on on	Σ	29b. Signature and title of certifier MD.	29c. License number D 19427	29	d. Date signed (Month	
			Allendy Thype			0 ( ' (	
	0		30. Name and address of person who completed ause of death (Item 23a) (Ty		Frodonia	ן. MU טעניע	Q
	Sta	te	Anwar T. Munshi, M.D. 110 Hospital 31. Date filed (Month, Day, Year) 32. Registra Signature	III., #303, PITIICE	TIEGELIC	WID 2001	O
	Registr	ar	31. Date filed (Month, Day, Year)  AUG 1 5 2006	T. Sparke			

DHMH 17 Rev 1/2001

06-06257 Robert Windle

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 27341

		1- For State Certificate	e of Death	_	F	Reg. No.	
Physici		Decedent's Name (First, Middle, Last)	3. Time of Death				
/ledical Exami		Robert James Windle			Month August 2	Day Year 1, 2006	0710 hrs
		4a. Facility Name (if not institution, give street and number) 2600 Tower Oaks Boulevard	4b. City, Town, o	r Location of D	eath	4c. County of I	i i
Funeral		Social Security Number 6. Sex 7 Age (In yrs. last birthda	ay) If Under 1 Ye	ar If Under 24	Hrs. 8 Date of 8	irth(MM/QD/YYYY)	9 8irthplace (State or oreign
Director		213-90-1388   XM 2 F 41	Yrs. Months Da		Augus 196		Country) Portugal
	[	Usual Residence of Decedent  10a State 10b County 10c City, Town or					10d. Inside City Limits
£ :		10a State 10b County 10c City, Town or North P					1 Yes 2 X No
Aaryland 28a-f show any 1.at once.		,					
ne Maryland or 28a-f sho ffed at once	ğί	10e. Street and Number	10f. Zip Code			10g. Citizen of What	
ith the 23a or notifie		15046 Joshua Tree Road	2087	8		United	States
h witl ms 2 be n	- āi l		<ol><li>Was Decedent of H If Yes, specify Cuba</li></ol>			o- 14. Race - A White, 6	American Indian, 8lack, etc.
deat or ite	Fun	1 Yes 2 No					T.Th. i.e.
safter ral", iner	à	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X N		l afadı alama	Specify: 16b. Kind of 8usir	White
5-0036 led within 72 hours after death with the Maryland Hyglene other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once			cedent's Usual Occupa ing most of working lif			16b. Kind of 6usir	less/industry
36 in 72 han ⁴	ompleted		intenance	Enginee	er	Buildin	g Maintenance
15-003( filed within I Hygiene ed other tha	ē	17 Father's Name (First, Middle, Last)				Maiden Surname)	8
21215-0036 uld be filed within 7 Mental Hygiene marked other than e event, the Medica	Be C	Glen Edmund Windle		Sc	si Papaz	ian	
2121; uld be fil Mental H marked	9	19a Informant's Name/Relationship (Type, Print ) 19b. N	Mailing Address (Stre	eet and Number	or Rural Route Nu	imber, City or Town,	State, Zip Code)
MD 2 d 2 shoul Ith and M n 27 is n		Glen Edmund Windle/ Father 15	046 Joshua	Tree R	Road, Nor		c, MD 20878
			Disposition (Name of c	emetery, A	ugust 22	20c. Location - C	ity or Town, State
mor Pages nent of nnt: If		1 Burial 2 Cremation 3 Removal from State craggeton	ropolitan rematory		2006	*	ria, Virginia
Baltimore, permit Pages I ar Department of Hes Important: If ite		4 Donation 5 Other Specify  21. Signature of Funeral Strvict Licerse	22. Name and Addres	ss of Facility	DeVol Fu	neral Hom	е,
Der Der	- 1	Alfa Jan	burg, MD 20877				
Physician		23a. Party Enter the disease, or complications that caused the death. Do not e failule: Vist only one cause on each line.	nter the mode of dying	g, such as card	iac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Difluorochloromethane	intoxicatio	n			Death
Adminer		or condition resulting in death)  Due to (or as a consequence of):					
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	nine	Course Enter Underlying Cause (Disease or injury that initiated					
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'8760, rificate be executed ing physician and as the burial - transit		d.					
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8760, tificate by ng physic as the bur	Σ	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 27	Fetal death 3	Ectopic pr	egnancy	23d. Date of de Month	Day Year
ox 68 eath certi attendin or use a	icia	past 12 months?  4 Pregnant at time of death 5	Other (Specify)				
Box 68 the death cert the attendir led for use a	Physicia	1 Yes 2 No 9 Unknown 9 Unknown					
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Vital Restriction: The his certificate director, page	Be C	25. Was case referred to medical	26.Pla	ce of Death (Ch	neck only one)		
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n of V ding Phy After tl funeral	n: T	(Month, Day, Year)		jury at Work?		e how injury occurred	
tend tend death ctor: y the	atic	Accident Pending Find 8/21/2006 Find	0.30 cm	Yes 2 No	Dubject	inhaled ref	
Division of Vital Records, ral or Attending Physician: The law requirement and Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 X Suicide 6 Could not be 28e. Place of Injury - At home, farm			28f Location or Town,	(Street and Number State) 2800 Tow	or Rural Route Number, City ver Oaks Blvd.
Divisior  Hospital or Attend 24 hours after death Funeral Director:	S	4 Homicide determined (Specify) Fnd mechanical			-		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or inv					
To the within To the comple	Med	29th Signature anytitle of gertifier	29c. Lice	nse number		29d. Date signed	(Month, Day, Year)
		MINXUA /VI	0.0	C.M.E.		August 22, 2	2006
		30. Name and address of person who completed cause of death (Item 23a)					
		Susan Hogan MD. Assistant Medical Examiner 111	Penn Street, Ba	altimore, ME	21201		
	24 Date filed (Street, Day Vees) 22 Begintra's Signature						
Regis		31. Date filed (Month, Day, Year) 2006 House 1					1

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Elizabeth Rebecca Winters Aug. 10, 8:30P M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Braddock 118 8. Date of Birth (Month, Day, Year) 915 Vindabona Nursing Home Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2□xF Months 224-05-2037 ٧X 91 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits worde r then "natural", or iteme 23s or 28s-1 ehov the Medical Examinar musi be notified at Frederick Jefferson MD 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 4108 Bennington Place West 21755 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ent: If item 27 Is marked other then "natural", or ite 1ry or other treumetic event, the Medical Examina 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) bakerv cake decorator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Carrie Unknown Thomas Hurst 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2010 15 19a. Informant's Name/Relationship (Type, Print) Linda Simpkins (Daughter) 4108 Bennington Pl. West, Jefferson, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2 XCremation 3 □Removal from State permit. Page Department c Importent: If eny injury or once. Smithsburg Crematory8/14/06Smithsburg, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licente Bornard Bss of Thompson Funeral Home 31 E. main St., Middletown, MD 21769 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease, or complications that or heart failure. List only one cause of Approximate Interval Between Onset and Death mmediate Cause (Final Cervahra Vascular ace **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, causing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or se a nonegouerne of) attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 20 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funarel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other 1 Yes 2 No 2 ER/Outpatient 3 DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/15/2006 an mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 gsh por, Brunsmy, mp21716 CHAN-HIMS HE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 2006 27343 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Yeer **Physician** Glenna Madeline Campbell Wresche August 8. 1:00 P 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brigadier Place - #E Montgomery Damascus Inder 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 □ F 579-26-6789 79 March 26, 1927 Director Virginia Usual Residence of Decedent the Maryland •how 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "neturel", or iteme 23s or 28e-f ehov the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Damascus 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20872 26012 Brigadier Place - #E U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Realtor permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if Item 27 is marked other eny injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jesse Furman Campbell Elton Gladwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20872 Self by pre-arrangement 26012 Brigadier Place - #E, Damascus, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven 8/29/06 Silver Spring, Md. 4 Donation 5 Other (Specify) 22 Name and Address of Facility Molesworth-Williams P.A., Funeral Home 21. Signature of Furneral Service Licensee Just 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY AKTERY DISCASE /Medical ue to (or as a consequence of): Examiner METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Noknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No ဥ filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 □ No 2 Accident Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examilitier: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54929 8/11/26 · CHILISTOPHOR K SINDA, MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONTCOMERY VILLAGE AVE. B-23 GAITH, MI DINHA, MI) 31. Date filed (Month, Day, Year) istrar's Signature State AUG 1 6 2006 Registrar

			1 - For State Registrar	State of I	Marylar	•		nt of H te of L			Re	g. No.	2006	27	344
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pu	3		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside	City Limits
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OUSD hours after	amin	by Fu	1 ☐ Never Married 2 X Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			1 🗆 Yes	2 X No	Specify:				Specify: W	HITE	
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e, R 1 and Health	ther ther		COLVIN YOUNG/HUS  20a. Method of Disposition	DAND	20b. F	Place of Dispo	sition (Na	ame of	ARTINS	Date Date	_		ation - City or	Town, State	
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<ul> <li>DIVISION OF To the Hospital or Attending Phy within 24 hours after death.</li> </ul>	Director: After I	Certification:	2 Accident investigi 3 Surcide 6 Could no 4 Homicide determin	ot be 28e. Place of	Injury - At h etc. (Speci	ome, farm, str fy)	M reet, facto		Yes 2 □ No		Location (St City or Town		Number or R	ural Route N	umber,
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Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Oldi	e or iviaryland /		ificate of De		Works, I	-	g No. 201	06 2734
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dical Exami	ner	4a. Facility Name	JTE (A	ALSTON give street and number)		4b Cit	v. Town, or Lo	ocation of Death	August 25,	4c. County of Dea	1825 hrs
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Funeral Director		5. Social Security			(In yrs. las		nder 1 Year nths Days	If Under 24Hrs Hours Mir	_	h(MM/DD/YYYY) 9. E	eign
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Physician /Medical		23 Part I. Erner failure. List o	the disse, or cor only one cause	m lightons that caused the caused	ne death. [	Oo not enter the mod	de of dying, su	uch as cardiac o	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
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n of ding Ph. h. taken t		27. Manner of De 1 Natural	ath 5 Pending	28a. Date of Injury (Month, Day, Ye Aug 5, 2006	ar)	28b. Time of Injury 0647 hrs	28c. Injury	at Work? s 2 ✔ No		ow injury occurred uto auto collisio	n
Division tal or Attendi rs after death. al Director: A	ertification:	2 Accident 3 Suicide	Investig	ation 28e Place of Inu	iry - At hon	ne, farm, street, fact			28f. Location (S	treet and Number or f	Rural Route Number, City
Divi	Certii	3 Suicide 4 Homicide	determi		al Street				or Town, St Washington		nery Rd , Elkridge, M
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ledical (	29a. Certifier 1 (Check only one)		ician: To the best of my ner:On the basis of exam							
To the To the comp	Medi	29b. Signature ar		and manner stated			29c. License		at the time, date a	29d Date signed (A	
		Donet 5	Kowsten 11	MD			O.C.M	.E.		August 26, 200	, ,
2			·	no completed cause of de	,	,					
				Assistant Medical		- W		ltimore, MD	21201		
S Regis		31. Date filed (Mo	AUG 3	32. Registrar	s Signature	1: Asa	William I				

DHIVIH 17 REV 172001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 10 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Clarence Roosevelt Allen, III 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE **Baltimore** Hanes If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 MM 2 F Director 215-60-1617 53 Sep 2, 1952 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or iteme 23a or 28a-f ehow the Moulcal Examiner must be notified at 10d. Inside City Limits **Funeral Director** Maryland N/A **Baltimore** 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 222 Mt. Holly Street 21229 U.S.A filed within 72 hours after death or iteme 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1971 1 ☐ Yes 2 ☐**X**No Specify: Completed by Specify: Black 3 Widowed 4 Drovorced 1974 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Veterans Loch Raven Rehab Technician 12 Ith and Mental Hygie 27 is marked other r treumatic event, III Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be filment of Health and Mental Hant: if Itam 27 is marked ott Clarence Allen Jr. Louise Julius 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise J. Allen Mother 222 Mt. Holly Street Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State tment 4 □ Donation 5 □ Other (Specify) 08/31/06 Owings Mills, Md. Garrison Forest Veterans Cemetery 21. Sign, ure of Funeral Service Liceos Depertiment on injury i 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death the death Immediate Cause (Final disease or condition resulting in death) Priysician mysendrel Infortan /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a nonsequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death Month Year 5 Other (specify) of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ temus (concer Completed 1 Yes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? 1 Yes 2 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 OA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1--Natural 5 Pending death. Director: / 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Rober (grande MD 900 Cates Aunce 31. Date filed (Month) 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

365818998

Ballinare MP

A-14121. 2006

State of Maryland / Department of Health and Mental Hygiene 2006 27347 For State Ragistra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** James R. Artis AUG 12:45 AM 28 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore ST AGNES BALTIMORE HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X 2 F 60 Yrs. Maryland 216-42-4985 Dec 14, 1945 **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "neturel", or Itame 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No **Baltimore** N/A Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2738 Mosher Street 21216 deeth v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notl Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Black Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry **Baltimore City Schools** Elementary/Secondary (0-12) College (1-4or 5+) Laborer permit. Pages 1 and 2 should be filed v Depertment of Health and Mental Hygien important: If item 27 is marked other th any injury or other traumatic event, the QDCs. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Addie Artis James Artis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2755 Mosher Street Baltimore, Maryland 21216 Vivian Jones Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ &remation 3 □ Removal from State 08/29/06 Catonsville, Maryland Metro Crematory, Inc. 4 Dopation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Physician 3 DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy signed by the ette Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ADVANCED cete hes been sig , page 2 should b AIDS 1 Yes 2 No 3 Probably 4 XUnknown 24b. Were autopsy lindings available prior to completion of cause of death? MULTIPLE CVAS 24a. Was an autopsy performed 200 No certificete HEPATITIS 1 Yes 2 🔀 No 1 Tes Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: / completely filled in by the f 2 Accident 6 ☐ Could not be 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) . MEDICAL RESIDENT Kwaman # P20659 28 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NTIM, KWAME SĨ AGNES HOSP. 900 CATON AVE BALTIMORE MD 31. Date filed (Month, Day, Year) AUG 3 0 2006 32. Registrar's Signature State ants) Server Si Registrar

A Mes

State of Maryland / Department of Health and Mental Hygiene,

1- State Amend item#8, perFH, 0858, 8/30/06 TT Certificate of Dooth 27348 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year LAURA A BOOKER 6:17 PM 406057 26 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA BON SECOURS HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 € F Months 213 · 30 · 8836 Usual Residence of Decedent 88 Director with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County worle in then "netural, or iteme 23s or 28s-f ehore the Medical Examiner must be notified at 1 XYes 2 No Director BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 317 CALHOUN STREET 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours efter 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ۾ 36 Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER DOMESTIC NA 12/14 GRADE or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Peges 1 and 2 should be fit timent of Heelth and Mental H tant: If Item 27 is marked off Be HARRY SUTION ELIZA CURRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER) BALTO. MO 21223 AUCE NELSON 317 CALHOUN ST. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t BBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Depertment of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS 09.06.06 BAUTO. MD 21. Signature of Funeral Service License 22. Name and Address of Facility VALIGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATO PIKE, BALTO. MD 21229 Vanghn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiovacular disease **Physician** /Medical Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s a consequence of): Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the aid be detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 ☐ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? certificete 2 No 1 Tyes 1 Yes or Attending Physician: After this certification, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 ☐ Inpatient 2 S ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 1 Yes 2 No filled in by the 2 Accident Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 | Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) Donatun H Llegen 15503 August 30 2006 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dolphin Street Baltimore MD ald 7 AMATUM A NAEEM 501 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 3 0 2006 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2006 27349 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6,2006 Physician MARGARET ELLEN BROWN /Medical 4c. County of Death Facility Name (If not institution, give street and number City, Town, or Location of Death Examiner ltimor NIA mar If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 6 Sex 7. Age (Ih yrs. last birthday **Funeral** Months Days Hours 1 □ M 2 1 F 24.40.096 MD Director Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a. State 10b. County r then "natural", or Iteme 23a or 28e-f ehow the Medical Exeminer must be notified at 1 Tyes 2 □ No NIA Director MD BALTIMORF 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1800 E. 291H STREET 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify: Specify: BLACK þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) If item 27 is marked other then College (1-4or 5+) Hygiene. HEALTH CARE SPECIALIST HEAUTH CARE NIA 111H GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Peges 1 and 2 should be nent of Heelth and Mental WALTER ANDERSON MARGARET SMITH ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD. # 131 3405 EDBEW000 THOMAS FENWICK BROTHER) BALTO. MO 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges 1 Depertment of H Important: If ite 08.31.06 BALTIMORE, MD 4 □ Qonation 5 □ Other (Specify) GREENMOUNI VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATU PIKE, BALTO. MD 212 21. Signature of Funeral Service Licensee any i Vanchn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner 50 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed and Due to (or as a consequence of): physicien Cai ξħ Physician/Medl ed by the attending p detached for use as 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ mknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificete has funeral director, page 2 # 1 Yes 2 12 No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendity within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \( \text{Homicide} \) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed e of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 27350

		1- For State Certificate of Death Reg. No.  1 Decedent's Name (First, Middle Last)  1 Decedent's Name (First, Middle Last)									) (	. 133				
Physicia		n/ 1 Decedent's Name (First, Middle,Last)  2. Date of Death  Month Day Year										3. Time of	Death			
dical Exami		Ernest			Ba	arber				/	Month August 22				1118	hrs
		4a. Facility Name (if not instituti	ion, give street and	number)		41	b. City, To	wn, or Lo	ocation of				County of	Death		_
		11 West 20th Street	Apt 8P				Baltimo	ore					N	Α		
Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs last bi	irthdav)	If Under	1 Year	If Under	24Hrs la	8. Date of Bi	rth (MM/D			olace (Sta	ate or
Director	. [	•				. a. a.a.y /	Months		Hours	Min.		01-19	142	Foreign	mtryMd.	
Director		217-40-6607	1 X M 2	F	64	Yrs					14-(	· + + ·	- 164	Cour	itry)	
>		Usual Residence of Decedent		· .	0- 0H T										04.1	000.1
. s		10a. State 10b. County		[1	0c. City, Tow									- 1		e City Limits
and shov	ᡖ	Md.	NA		В	altim	ore								1 △ Ye	s 2 No
laryli 8a-f	9Ct	10e. Street and Number					10f. Zip C	Code			1	l 0g. Citize	en of Wha	t Countr	y?	
he M I or 2 ified	Director	11 W. 20th S	treet	Apt.	8P			2123	18			τ	JSA			
215-0036  be filed within 72 hours after death with the Maryland ntal Hygiene rked other than "natural", or items 23a or 28a-f show any ent, the Medical Examiner must be notified at once.		11, Marital Status		Decedent E		13. Was	Decedent	of Hispa	anic Origin	n? (Spec	fy Yes or No	)- 1	4. Race -	America	n Indian	8 lack
r death v	Funeral		Married Arme	d Forces?_			s, specify					Ι.	White			7
현 등 팀		3 Widowed 4 D	ivorced If Yes, Give	es 2	<b>X</b> No	1 , ,	Yes 2X	No	specify:				Specify:	Bla	ck	
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Ď	15. Decedent's Education (Sp	or Dates:		leted) 16a	. Decedent				nd of wor	k done		nd of Bus			
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5-0036 iled within 7 Hygiene.	E	8th grade  17. Father's Name (First, Middle	- 1 1			Пак	JL CL	140	N & d = d   = = d =	M /F	Comp. B. All of all o					
Hyge dot			e, Last)		,			18		,	irst, Middle,	Maiden S		3		
21215-0036 uoid be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner	a	Ernest			rber				Glad	-			Hubb			
MD 21 2 should h and Me 27 is man	잍	19a Informant's Name/Relation									al Route Nur				(ip Code	
e, MD I and 2 sho Health and item 27 is		Lauren Siegel									more,		212			
nore, MD 3ages I and 2 shount of Health and It: If item 27 is rother traumatic		20a Method of Disposition 1 . 8urial 2 Crematic	n 3 🗆 Baman	al from Stat		of Disposit atory or other		of ceme	etery,		Date	20c. Lo	ocation - (	City or To	own, Stat	e
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Baltimore permit. Pages 1 Department of F Important: If injury or other		21. Signature of Funeral Service Licensee    22. Name and Address of Facility   Baltimore, March F.H. East   1101 E. North Av.										ve.	Z12	.02		
Physician		23a, Part I. Enter the disease, of	or complications th	at caused th	ne death. Do i							_			Approxir	nate Interval
/Medical		failure. List only one caus	e on each line.								•				Between	n Onset and Death
Examiner		Immediate Cause (Final diseas or condition resulting in death)				ic Cardio	vascula	I DISE	ase							
		Date to (a) as a solucidation of the														
	e.	Sequentially list conditions, if any, leading to immediate	Due to (or	as a consec	uence of):									$\rightarrow$		
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587 ertific fing p	an/	23b. Was decedent pregnant in past 12 months?	''	ve birth		2 Feta	al death	3	Ectopic p	pregnanc	у	N	Month	Da	у	Year
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Division tall or Attendians after death.	fice			Place of Inju	ıry - At home,	farm, street	t, factory, c	office bui	ilding, etc.	28	f. Location (		d Number	or Rura	Route N	lumber, City
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifit completely filled in by the funeral director,	Certification:		termined (Spec	cify)							or Town, S	state)				
Hosp 4 hot Tuner		29a Certifier	Physician: To the	best of my	knowledge d	eath occurr	ed at the ti	me. date	e and place	e, and du	e to the cau	se(s) and	manner s	s starter	1	
To the Hos within 24 h To the Fun completely	Medical	(Check only	aminer: On the ba	isis of exam												
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h		30. Name and address of person				*		_								
		Patricia Aronica-Poll		istant Me	edical Exa	miner	111 Per	nn Stre	et, Balt	imore,	MD 2120	11				
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			1 - For State Registrar	State of Ma	aryland / De	epartmen Pertificat	t of H	ealth ar Death	nd Mental	Hygier Reg. 1	200	)6	2735	
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5-0	72 hc	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(G	ecedent's Usua Bive kind of wo	rk done d	urina most o	of working	16b.	Kind of Bu	siness/In	dustry	
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Je,	es 1 and 2 of Health of Hem 27 i		20a. Method of Disposition		20b. Place of Di	isposition (Nar.	ne of		Date	-	Location -			
E	Page nent c int: if		1. Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  King Mem. Park  8-26-06  Randallstown,											
Baltimore,	permit. Pages Department of importent: if It eny injury or one		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 2120											
<u>m</u>	8259		March F.H. East 1101 E. North Ave.  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate											
	eath certificate be executed  Exam  ettending physicien and for use as the burial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of):								Onset and Death	
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of	Attending Physician: r death. sctor: After this certific by the funeral director,	To To	27. Manner of Death	1 ☐ Inpatier  28a. Date of Injur  (Month, Day			8c. Injury Work	4 🗆 14012	ing Home 5 1		jury occurre		) HOSPICE	_
o	nding tth. :: Afte	tion	Natural 5 Pending 2 Accident investigation	(Month, Day	<i>Year)</i> Inju	ry M		? ′es 2 ∐ No	, l					
Divis	in Plant	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office 28f.						on (Street Town, St	and Numbe	er or Rura	l Route Number,	
	To the Hospitel within 24 hours of the Funeral completely filled	edical C	29a. Certifier 1 Certifying Phy	sician: To the best of ner: On the basis of	of my knowledge, d	leath occurred	at the tim	e, date and	place, and due to	the cause	(s) and mai	nner as si	ated.	_
	the hin 24 the F	Medi	one)	and manner sta	ted.				- Joan of di ind (					
	To Too	-	29b. Signature and title of certifier	/_		290	: License		26	1	Date signed	-		
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_	3		30. Name and address of person who co	1 MOOD	2300 Z	pe, Print)	1 Va	lley 1	Ed Tim	onlu	M, N	rd	21093	
	Sta Registi		31. Date filed (Moath, Day, 3 ear.) 200	6 32 Registra	ur's Signature	pedi	•	1						

18,2006

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month DO PM **Physician** 21-00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner RIVEY RO. YE ARUNDEL If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1 M 2□ F Hours 216-62-197 Director KENTUCKY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD 1 ☐ Yes 2 No Funeral Director 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code ō .S.A. or items 23a 1060 APT. 520 ス 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 1 Yes 2 No If Yes, Give Year or Dates: 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Whi TE þ 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. Is marked other then College (1-4or 5+) RSING ASSISTANT Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ( permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 Is marked any injury or other traumatic evone. LOYD WAKLEY LONA ARIZONA MAGGARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daugherty Family Funeral Home And Cremation Center, P.A. SANDRA LOVELACE. 2001 Mountain Road - Pasaderia, M.J. 21122 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State TOWE TS REGISTRY 8-28 4 □ Donation 5 □ Other (Specify) of Fundral Service Licen 22. Name and A dress of Facility 21. Signature Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 23 Part 1. Enter the disease, comulication in at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur and only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician myolanpia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine DE PECTE The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 2 10 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 1 Yes or Attending Physicien: 25. Was case referred to medical xall iner? 28. Place of Death (Check Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Yes Certification: To 2 🗌 No 5 desidence 6 □Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death Valural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu the

Samuy Physiapa completed cause of death (Item 23a) (Type, Print) OTTOME AIBHWOD? 757 85527 m.g.

State Registrar

31. Date filed (Month, Day, Year) AUG 3

0 2006

29b. Signature

32. **∌**egistrar's Signature

State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:20 AM Edward Brown 08 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NIA Baltemore VA Mederal Conter Baltemore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | North | Day Year | North | Day Year | North | Day Year | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | Nor 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 213-46-4810 59 Maryland Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show other treumatic event, the Medical Evanding must be nutitied at 1 ☐ Yes 2 ☐ No Baltimore Maryland Director Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Court 21234 3 Lava Apt. A U.S.A. Івте 23а Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. int: If item 27 Is marked other than "natural", or Iteme 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Vietnam 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Driver Taxi Cab 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Andrew Aaron Brown Olivia Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette Shiflett - Sister 12105 Maddox Lane Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 0 permit. Page Department of Important: If any injury or once. Garrison Forest Cem. 09-06-2006 Owings Mills, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Charles Miner 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Mines Baltimore, Maryland 21214 harles 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Colorectal Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sician and The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 2 Accident hours after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide within 24 hours a To the Funeral ( 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P17400 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 N. Greene Street Bultimore, MS 21201 José C. Cabassa MS 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar AUG 3 0 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. NZ 006 27354 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 8:12 P M Kenneth Stanley Bauer, Sr. 23 2006 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 XM 2 ☐ F 217-28-7484 June 11, 1930 Director 76 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ?? is marked other than "naturel", or Items 23a or 28a-f show traumatic event, tre Modical Examinate ust by motified at Baltimore 1 ☐ Yes 2 X No Maryland Catonsville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 719 Maiden Choice Lane HR 114 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. be filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Associate Engineer Telephone Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ages 1 and 2 should be file of the file of Health and Mental H to them 27 is marked out Charles Bauer Minnie Marie Bauer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 719 Maiden Choice Lane HR114, Catonsville, MD 21228 <u>Florence Bauer</u> other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ' 1 

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or injury or Crest Lawn Mem. Garden 8/28/2006 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee 1630 Edmondson Avenue: Catonsville MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HOURS ACUTE INTRACEREBRAL HEMORRHAGE Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical been signed by the attending a should be detached for use as IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of Renal Cell Carcinoma 24a. Was an prior to completion death? autopsy performed? es 2 \( \square\) No funeral director, page 2 1 X es Division of Vital 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification; To this 27. Manyer of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death the 1 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 5 within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 24, 2006 D0037359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kris M. Shekitka, M.D. 900 Caton Avenue Baltimore, MD 21229 31. Date filed (Mo AUG , Xear) 32 Registrar's Signature State 2006 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1353 PM Brown Darrian 2000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Director Yrs. 218 73 2194 N/A 10 OCT. 4,2005 MARYLAND Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 √Yes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1006 E. CHASE STREET BALT'IMORE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 € No Specify: 2 Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) N/A NONE NONE or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Health and Mental DARRIN J. BROWN CANDICE MERRITT ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Importent: If Item 27 is
eny Injury or other trau CANDICE MERRITT/ mother 1006 E. CHASE STREET BALTO MD. 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date t Donation 5 □ Other (Specify) GARDENS OF FAITH CEMETERY BALTIMORE, MD. 21. Sigrature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCI SCRUGGS FUNERAL HOME В. 23a. Part1. Enter the disease, or complications that caused the leafh. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21213
Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) Syndrome Due to ( as a consequence of): **Physician** BIR TH /Medical Examiner · Congestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed ettending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy perfor 1 Yes 2 No 1 Yes To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To 28a. ate of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 6 Could not be determined 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

All Medical Examinities: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name an laddress of person who collapsed cause of death (Item 23a) Type, Print) 600 North Wolfe Street, BALTIMORE, MARYLAND 21287 RIBIAINE EASLET, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

	la constitution of	1 - For State Registrar	State of M	aryland		artmen rtificat			and M		Reg. No.	006	2735	56		
Physic	ian		Decedent's Name (First, Middle, Last)  2. Date of Death Month													
/Medi Examir	cal	Geraldine Dever  August 2  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death										4, 2006 6:00 PM				
Exami	ner	Genesis Heritage	-					undal				Ltimore				
Funeral Director		5. Social Security Number 214-44-7914	5. Sex 7. Ag 1 M 2 <b>X</b> F	ge (In yrs. Ia 60	st birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da 01/12/	v, Year)	9. Birth Cou	place (State or F intry)	oreign		
D .		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	oation						10d. Inside City Li				
Aaryia f sho	٥	MD Baltim	ore	Dunc		,cation							1 Tes 2			
288-	Director	10e. Street and Number	Dane		10f. Zip	Code				10g. Citiz	en of What Co	intry?				
h with	a D	7232 German Hill	Road			212	22				USA					
ING 21213-0036  be filed within 72 hours after death with the Maryland tital Hygiene. Indicate than "natural", or Itams 23a or 28a-f show svent, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	Ever in U.S		Was Deced If Yes, spec	1 -	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	ocify Yes or No Rican, etc.)		4. Race - Amer Black, White Specify White	nite, etc.				
Maryland 21215-0035 wd 2 should be filed within 72 hours af th and Mental Hygiene. Z7 Is marked other than "natural", or traumatic svent, the Medical Exam.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0·12)	5+)	(Give life.	dent's Usua kind of wo DO NOT us	rk done di	urina most	of workii	ng		d of Business/l Estate	•				
TC C1Z1 be filed within stal Hygiene. od other than "	Be Co	12 17. Father's Name (First, Middle, La	ast)		Secre	cary				(First, Middle,	Maiden S	Sumame)				
Aarylan 2 should be 2 and Mental 1s marked o raumatic sve	To	Joseph Drehoff						Vivia								
		19a. Informant's Name/Relationshi Lori Tyson/Daught				-				<i>l R</i> oute <i>Numbe</i> <b>ltimore</b>		Town, State, Z. 21229	p Code)			
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	_	cei	nce of Dispo metery, crea sapeal	natory or o	ther place	- 1	A	ug 26 006		ation - City or 1	own, State Maryland			
Baltimo		21. Signature of Funeral Service Li	censee R.H. M	ALVV3	_ C		on ar	nd Fur	ieral	Alterna			vland			
Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   TRIAL F BRILLATION  Due to (or as a consequence of):												en ath		
Examiner political property of the property of	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. ATHE Due to (or as	A TION PHEUMONIA								ASE				
icate be executed physicien end s the buriat-transit	dical Ex	resulting in death) Last	Due to (or as	7/7	ence or):											
death certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N							Ectopic pregnancy Other (specify)						
HECONGS, P.O. The law requires that the tens been signed by the age 2 should be detache	by	111111111111111111111111111111111111111									acco use contribute to the cause of death?  s 2 \( \sum No \) 3 \( \sum \) Probably 4					
- 0 4	Completed	24a. Was an autopsy perform: 1									sy	24b. Were aut prior to co death? 1 \( \text{Yes}	opsy findings ava ompletion of caus	alable se of		
Of VITAL H Physician: The rthis certificete h ral director, page	Be	25. Was case referred to medical examiner?	Hospital:				- OH-		of Death	(Check only o						
Phys this al dil	2	1 Yes 2 No  27. Manner of Death	28a. Date of Inju		R/Outpatier 28b. Time o		8c. Injury	41000	-	ne 5 Resid		Other (Spec	fy)			
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UIVISION of or Attending of after death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	289. Place of in	Place of Injury - At home, farm, street, factory, office 28f. Location (Street city or Town, St. 28f. Location (Street City or Town) (Street City or Town) (									et and Number or Rural Route Number, State)			
UIV  To the Hospitel or A within 24 hours after or To the Funerel Direct	edical	(Check only 2 Medical Ex	Physician: To the best kaminer: On the basis of and manner st	of examination	ledge, deat on and/or in	occurred vestigation,	at the time in my opi	e, date and inion, deat	d place, a	ed at the time, o	date and p	place, and due	to the cause(s)			
To t With To t	2	29b. Signature and title of certifier	16 Juli		MD		License	27/	188		8	signed (Month)	Day, Year)			
1	ے	Sevinse 1	to completed cause of a	death (Item : 2 rar's Signati	11-	Print)	P	lace	A	unda	OK!	MO.	2/22	2		
Sta Regist	ate rar	31. Date filed (Month Day, Year) AUG 3 0	2006 32 Tegistr	rar's Signati	A Section	esti										

DHMH 17 Rev 1/2001

06-06365 Gilbert Dorsey

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

,		1- For State Registrar	o o maryana na n	Certific	Reg. No. 2006 2735								
Physicia edical Examir	ın/	1. Decedent's Name (First, Middle,	Last)		r	orsov	2. Date of Death Month	Date of Death Month Day Nugust 25, 2006  23. Time of Death 1327 hrs					
eulcai Examii	lei	Gilbert  4a. Facility Name (if not institution,				orsey		st 25, 2006 1327 IIIS					
		St. Agnes Hospital			Baltimo	re		, , , , , , , , , , , , , , , , , , , ,					
Funeral		, , , , , , , , , , , , , , , , , , , ,	. Sex 7. Age (In	yrs. last birt			Min	(MM/DD/YYYY) 9. E					
Director		214-76-4256 1X M 2 F 46 Yrs. Months Days Hours Min. 08 15 60 Foreign Country) MD											
á	ŀ	Usual Residence of Decedent  10a. State 10b County	100	c. City, Town	or Location				10d. Inside City Limits				
d how a	_	MD NA											
arylan 8a-f s at on	Scto	10e. Street and Number			10f. Zip Ci	ode	10	g. Citizen of What Co	ountry?				
n with the Maryland ms 23a or 28a-f show any be notified at once.	Ģ	43 South Culv	er Street			21229		U.S.A					
eath with items 23	Funeral Director	11. Marital Status  1 X Never Married 2 Marr	12. Was Decedent Eve Armed Forces?	er in U.S.			n? ( Specify Yes or No- Puerto Rican, etc.)	14. Race - Am White, etc.	erican Indian, 8lack,				
er deal			1 Yes 2 X	No	1 Ves 2 V	No specify:		Specify:	Black				
urs aft tural"	à		's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Busines										
5 72 ho m "na cal Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		during most of working		·	_	_				
within jiene.	d mo	12th grade  17. Father's Name (First, Middle, L.	na na	F	ork Lift		Name (First, Middle, M		Company				
215-0036 be filed within 72 hours after death with the Maryland ntial Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Be C	Alfred Dorsey					B. Reddi						
imore, MD 21215-0036  gages I and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or ite or other traumatic event, the Medical Examiner must	일	19a. Informant's Name/Relationship	(Type, Print)			Street and Numb	per or Rural Route Num	ber, City or Town, Sta					
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Baltimore, permit. Pages I an Department of Hea Important: If ite		20a Method of Disposition  1 X Burial 2 Cremation	3 Removal from State		of Disposition (Name ory or other place)	of cemetery,	Date	20c. Location - City	or Town, State				
time trant:		4 Donation 5 Other Specify: Arbutus Memorial Park 8/30/06 Arbutus, Md  21. Signature of uneral Service Licensee Park 8/30/06 Arbutus, Md  22. Name and Address of Eacility March F/H West											
Baltimore, MC permit. Pages I and 2 s Department of Health a: Important: If item 27 injury or other traum		21. Signature at uneral Service Li	Sensee (		March H	TH Wes	t ve, Balti	moro. Má	21215				
Physician		23a. Part I. Enter the disease, or confailure. List only one cause or		death. Do no	ot enter the mode of	lying, such as ca	rdiac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and				
/Medical Examiner	- 0	Immediate Cause (Final disease	a Narcotic (her	oin) in	toxication				Death				
		or condition resulting in death)	Due to (or as a conseque	ence of):									
	Ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):									
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ecuted and - transit													
ial jan	/Medical	X UNPENDED	AMENDED item#	23a,27,	28a-f,perME,	g859,9/11	/06 TT						
		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of					23d. Date of deliver	ery Day Year				
	icia	past 12 months?  1 Yes 2 No 9 Unknown	4 Pregnant at time		Other (Specify								
M P P P	Physiciar	Part II. Other significant conditio	9 OHKHOWH	it not resultin	a in the underlying c	use given in Par	t I 23e. Did tol	pacco use contribute	to the cause of death?				
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Division of Vital Records, rate or Attending Physician: The law require at or Attending Physician: The law require at Director. After this certificate has been sited in by the funeral director, page 2 should be	다	examiner? 1 ✓ Yes 2 No		2 <b>Y</b> ER/O				Residence 6 Oth	er:				
n of viding Ph.	:	27. Manner of Death  1 Natural 5 Pendir	28a Date of Injury (Month, Day, Year)	1		c Injury at Work? 1  Yes 2	No.	ow injury occurred					
iSior Attender er death rector: oby the	icat	2 Accident Investi	gation 28e Place of Injury		arm, street, factory, o	41		treet and Number or I	Rural Route Number, City				
Divisions pital or At ours after deral Direct filled in by	Certification:	3 Suicide 6 A Could 4 Homicide determ		æ			Baltimore	ate)43 S. Cult , MD	Rural Route Number, City var Street				
Division of Vital I To the Hospital or Attending Physician: within 24 hours after detect. To the Funeral Director: After this certif completely filled in by the funeral director.	Medical (	(One on only	sician: To the best of my kn iner:On the basis of examina	-									
To To Cor	Me	29b. Signature and title of certifier	and manner stated,		29c. I	icense number		29d Date signed (A	fonth, Day, Year)				
		Lanck Fruith	aut mo			D.C.M.E.		August 26, 200	6				
		30. Name and address of person w			111 Don- Ct	ot Boltima	MD 21204	· <del></del>	·				
	ate	Pamela Southall, MD  31. Date filed (Menth. Day Year)	Assistant Medical Ex		111 Penn Stre	ei, Dailiniore	:, IVID Z I ZU I						
Regis	ate trar	/////- 7 //	2006 32. legistrar's S	K	Coule								

			For State Registrar	State o	of Maryland		irtment of H tificate of I		ene g. No. 20	006 27358						
	Physicia		Decedent's Name (First, Middle	e, Last)	Valerie	Dent			2. Date of Death Month							
	/Medic Examin		4a. Fecility Name (If not institution	n, give street and nu	ımber)			Location of Deat		4c. County o		Death N/A				
	Funeral Director		5. Social Security Number 212-72-7829	6. Sex 1 □ M 2 □ X F	7. Age (In yrs. la	24	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	Year)	Count	irthplace (State or Foreign Country) Maryland				
3	2		Usual Residence of Decedent  10a. State 10b. County			Town or Lo	cation		3017,	100.		d. Inside City Limits				
1	or 28a-f show	Director	Maryland	N/A				altimore		G'2'		1 Yes 2 No				
1	23a or 2		10e. Street and Number 2303 East Madisor	1 Street`			10f. Zip Code	21205	10	g. Citizen of W	U,S.A.					
permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any Injury or other traumatic event, the Medical Examinar must be multiled at once.	al', or items	by Funeral	11. Marital Status  1 Never Married 2 Mar 3 Widowed 4 Divorced	ried 1 ☐ Yes	2 □ <b>X</b> lo ive	li li	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)		- America , White, e					
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מומל	ental Hygis ked other c event, it	To Be Co	12 17. Father's Name (First, Middle,	Last) Walter Dent				18. Mother's Nar	aiden Sumame orliss Dent	· ·						
Wan y	th and Mark is in the second of the second o	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1701 Eutaw Place - #108 Baltimore, Maryland 21217										
ווכוני מיני	nent of Hea Int: If Item 2 Iry or other		20a. Method of Disposition  1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Arbutus Memorial Park  20c. Location - City or Town, S  20d. Place of Disposition (Name of cemetery, crematory or other place)  Arbutus Memorial Park									3. 554				
	Departi Departi Importu any Inju		21. Signature of Funeral Service	Licensee	JON S	A 22	Name and Address Estep I	ss of Facility Brothers Fur Lutaw Place	neral Service, Baltimore, Md	P. A. 21217						
P	hysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Immediate Cause (Final disease or condition.													
	/Medical xaminer		resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  THR 112F													
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O VOO .	rise fav requires frat frie death Certificate be sociated at the has been signed by the attending physicien and page 2 should be dateched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregnan birth 2   Fetal on nant at time of dea nown			of deliver	delivery Day Year							
	signed by	þ	Part II. Other significant conditi		cause of death?											
1000	has been ge 2 shouk	Completed		24b. W		are autopsy findings available or to completion of cause of										
	ertificate actor, pa	Be Co	25. Was case referred to medica examiner?						1 ☐ Yes 2 Th (Check only one	<b>№</b> No 11	☐ Yes 2	P□ No				
	to the note that the name within 24 butter of the name within 24 butter start of the Funerst Director; After this certificate has completely filled in by the funeral director, page 2	tlon: To	1 Yes 25 No  27. Manner of Death 1 Natural 5 Pendi	28a. Date		R/Outpatien 28b. Time of Injury	28c. Injun Worl	4 Prursing F	dome 5 Resider 28d. Describe how							
	effer deat Director: d in by the	Certification:	3 Suicide 6 Could	not be 28e. Place	e of Injury - At hor ding, etc. (Specify)	me, farm, stre			28f. Location (Stre City or Town,		r or Rural	Route Number,				
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	withir To th	W	29b. Signature and title of certifie	Redo	sly	MD	29c. Licens	number 16HH	29	d. Date signed	(Month, D	ay, Year)				
	4		30 Name and address of peredr	who completed cau	se of beath (Item	23a) (Type,	Print) 312 Bo	Ulino	e MD	2120	1					
	Sta Registr		31. Date filed (Month, Day, Year AUG 3	0 2006 32.1	Registrar's Signatu	TLE	best									

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

James Robert Eyl	1	- For State	tate	of Maryla	nd / l	•	ment of icate of			Menta	al Hy	_	eg. No.	20	06	273	35	
Physiciar		Registrar 1. Decedent's Name (First, Mid	dle,Last	)					_		2	2. Date of Deat	th			Time of Death		
Medical Examin		James Robert Bybs														0022 hrs		
pus-	Н	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Mount Carmel & Gunpowder Rd  Upperco											4c. County of Death Baltimore County					
Funeral	=	5. Social Security Number	6. Se		7. Age (	In yrs. last b	oirthday)	If Under		If Under	24Hrs.	8. Date of Bir			9. Birthplace (State or			
Director						29	Yrs.	Months		Hours	Min.	1			reign Country			
	ŀ	219-88-4988 Usual Residence of Decedent	'A	1X M 2 F 2			115.	1	L			05/25/	19//			MD		
any	Ī	10a. State 10b County 10c. City, Town or Location									d Inside City Li							
and Show	5	PA Yo	ck			S	Stewartstown							1	Yes 2 X	No		
Maryl 7.28a-	Director	10e. Street and Number						10f. Zip C	Code			1	0g Citizen	of What (	country?			
r death with the Maryland or items 23a or 28a-f show must be notified at once.		176 Hollow R	oad	12. Was Dec			U.S. 13. Was Decedent of Hispanic Origin? (Spe							USA				
ath wi	Funeral	11. Marital Status  1 Never Married 2 X	_						city Yes or No Rican, etc.)		White, et		Indian, Black,					
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than re event, the Medica	Š B	To mother's Name (First, Middle, Last)																
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Baltimore, permit. Pages 1 ar Department of Her Important: If ite	Ĩ	21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reistersto																
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Box 68760 he death certificate to the attending physhed for use as the b	sician/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the	23c. If yes, of 1 Live b		or pregnan		al death	3	Ectopic p	oregnan	су	Mo	ate of deli nth	Day	Year		
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ding Ph	ٳؾۣ	27. Manner of Death  1 Natural 5 Death		28a. Date FOUND	of Injury Day,Yea		b. Time of In	· ·		at Work?	Ir	28d. Describe l Priver auto			sion			
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15	1	30. Name and address of person				•			- 147		0400							
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Sta	ite																	

State of Maryland / Department of Health and Mental Hygien 2006Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** MARY FloyD OS 28 1510 00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mercy Medical Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2X F Yrs. Director 217-74-1302 85 Feb 9, 1921 No.Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itsms 23a or 28a-f show the Medical Exeminer must be notified at **Baltimore** 1 Yes 2 □ No N/A **Funeral Director** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1110 Scott Street 21230 U.S.A filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. Black Be Completed by 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 If item 27 is marked other or other treumatic sysnt, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill timent of Health and Mental H tant: If item 27 is marked other. Maggie Shaw Unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1110 Scott Street Baltimore, Maryland 21230 Symanthia B. Floyd Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If sny Injury or once. 09/02/06 Whiteville, No. Carolina 4 ☐ Donation 5 ☐ Other (Specify) Cherry Grove Cemetery 21. Signatur 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stomach Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, To Be Completed by Physician/Medical ihe IF FEMALE. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached t Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 1 🗌 Yes 2 🗌 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient LEE utpatient 3 DOA this 28a. Date of Injury (Month, Day Year) filled in by the funeral Medical Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Alatural 2 Accident 5 Pending investigation death. 1 Tes 2 No within 24 hours after deat To the Funerel Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29c. License number 29d. Dayle signed (Month, Day, Year) 29b. Signature and title of certifier use of death (Item 23a) (Type, Print) 11 31. Date filed (Month, Day, Year) AUG 3 0 2006 Registrar's Signature State saces. Registrar

1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 24, 2006 2:25 A M Shirley Mae Fisher August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Arbutus 1077 Elm Road 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Number 219-18-8891 **Funeral** Months Days Hours Min 1 □ M 2 F Yrs. Dec. 3, 1925 Maryland Director Usual Residence of Decedent 10d. Inside City Limits with the Manyland 10a. State 10c. City, Town or Location 10b County itama 23a or 28a-1 show the Medical Examinat must be notified at 1 Yes 2 No Arbutus MD Baltimore Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 United States 1077 Elm Road Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status White 1 Never Married 2 Married 1 ☐ Yes 2 🖁 No Baltimore, Maryland 21215-0036 ō Specify. 3 Widowed 4 □ Divorced Year or Dates "natural", 16b. Kind of Business/industry 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) during most of working al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11 nt of Health and Mental Hygis t; If Item 27 is marked other y or other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Lee Cecilia Green 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1077 Elm Road, Arbutus, MD 21227 Gary Fisher - Son 20b. Place of Disposition (Name of Wester Place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Depertment of H Important: If its any injury or ot once. 1 ☐ Burial 2 🖟 Cremation 3 ☐ Removal from State 08-28-06 Odenton, MD Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Yeur **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, any, leading to infractall cause. Enter Underlying Cause (Disease or injury Examiner perlipidemin Hospital or Attending Physician: The law requires that the death certificate be executed
 24 hours after death.
 Funeral Director: After this certificate has been signed by the ettending physician and ettending physician and for use as the burial-transit that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 Unknown tailure 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Tyes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient ၉ 28c. 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 27. Manner of Death Certification: Injury 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D25861 who complete cause of death (Item 23a) (Type, Print) 716 Maiden Choice Lane Stute 101 Bastimore, Maryland 21228 116 Madei State Registrar

State of Maryland / Department of Health and Mental Hygien 2006 27362 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Gould 21:35 PM J. Andrew August 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Baltimore Union Memorial Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours 1**∑**M 2□ F 262-22-8339 Yrs. Director 91 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r then "neturel", or Items 23s or 28s-f shorthe Medical Examiner must be notified at 1 XYes 2 ☐ No Director NA Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 USA 2740 E. Chase Street Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 √ Yes 2 □ No IF Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 ₩ Widowed 4 □ Divorced Completed by Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer llth grade and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event ang: Be Mary Gould Jane Ball Gould Archie ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 N. Poppleton Street, Baltimore, Md. Daughter-in-law Sundae White 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, Md. Garrison Forest Vet. 8-30-06 21. Signature of Fune A Service Licensee 22. Name and Address of Facility Mille March F.H. East 21202 1101 E. North Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 weeks **Physician** Preumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed **burial-transit** Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien Physician/Medical the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) be deteched 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☑ Inknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 2 ER/Outpatient 3 DOA Pis. 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; After 1 DNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. filled in by the f 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20063176 CARRENTWACHEREN MD August 22, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D Union Chiengenus 1
31. Date filed (Month, Day, Year)
AUG 3 0 2006 Menor Wachinemer 32: Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 0 1 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death AUGUST 27,2006 Physician V. GREGOREK 10:15 pM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4 N. MILTON AVENUE BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Pear) MAY 2, 1922 9. Birthplace (State or Foreign Country)
NEW YORK 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2**X**F 053-14-5790 84 Vrs Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 4 N. MILTON AVENUE 238 21224 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Be Completed by 3XWidowed 4 □ Divorced "naturel" 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done di life. DO NOT use retired) during most of working Hygiene. Elementary/Secondary (0-12) 1 2 College (1-4or 5+) HOUSEWIFE DOMESTIC Pages 1 and 2 should be filed v thent of Health and Mental Hygie tant: If Item 27 is marked other t jury or other traumatic event, in 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) THOMAS LOBACZ BALBINA DURKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORA TROTZ/ DAUGHTER 6910 BROOK AVENUE, BALTIMORE, MARYLAND 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Department or important: If any injury or once. SACRED HEART OF JESUS 9/1/06 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Z TLLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dving, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760, Completed by Physician/Medical as IF FEMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 pronths?

1 Yes 2 No
9 Unknown ō 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No certificate 2 No 1 Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 36 NO Hospital: Other: 4 \sum Nursing Home ome 5 Residence 6 Other (Specify)
28d. Sescribe how injury occurred ၉ 1 🗌 Inpatient 1 Tes 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation Natural Accident 1 ☐ Yes 2 ☐ No М death. Director: / 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Direct 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) 29c. License number 2006 82. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2006 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 28 2006 20 GILDEN BESSIE 4:46 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NORTH EAST 33 DOCTOR CARR ROAD CECIL 9. Birthplace (State or Foreign Country) 5. Social Security Number Funeral 1 ☐ M 2**V**☐ F PA 218-46-0216 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itams 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No CECIL **PERRYVILLE** Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1214 CEDAR CORNER ROAD 21903 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No þ Specific 3 Nidowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Deperment of Health and Mental Hygien. Importent: If Item 27 is marked other that any Injury or other traumatic event, Item 2006. **CLERK** GROCERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KUSHNER **ESTHER** TAYLOR **JACOB** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) PHILLIP GILDEN / SON 1214 CEDAR CORNER ROAD - PERRYVILLE, MD 21903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State WOODLAWN, MD HEBREW YOUNG MEN CEM. 08/29/2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HyperTension /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes : After this certification of funeral director. 25. Was case referred to medical examiner? Be ASSISTED 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) LIVING 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No I Director; A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours after To the Funaral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D0026183 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h AUE. NOTTH EAST. Sachder. M.D. 322 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 0 2008 Registrar

Amend item#26, peril D, 0858, 8/30/00 IT 27365 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ΆΰĠUST ፟፝ፇ፟, 2006 **GLASSBERG** PAULINE 8:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5502 HARRIS FARM LANE CLARKSVILLE HOWARD If Under 1 Year | If Under 24 Hrs. 8. Birthplace (State or Foreign Country)
 RIV 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (1912) **Funeral** Days Months Hours 1 □ M 2 😿 F NY 94 104-28-8059 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show 1 ☐ Yes 2 No by Funeral Director HOWARD CLARKSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 5628 TROTTER 21029 ROAD 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LEGAL SECRETARY LAW Ith and Mental Hygie 27 is marked other if treumatic event, II othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be KLUGERMAN (UNOBTAINABLE) YETTA NATHAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: if item 27 ie
eny injury or other treu 5628 TROTTER ROAD - CLARKSVILLE, MD 21029 ELAINE ROGERS / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State ARARAT CEMETERY 08/29/2006 FARMINGDALE, NY 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Septice Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Immediate Cause (Final diseast or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Thesidence 6 Mother (Specify) 1 ☐ Yes 2 D No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

06-06301

Please Type or Print in Black Indelible Ink John Harding State of Maryland / Department of Health and Mental Hygiene 2006 27366 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month Day August 23, 2006 Medical Examiner John Alfred Harding 0546 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 7251 Fairbrook Road Woodlawn **Baltimore County** 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Director 218-62-3562 11-13-1954 1 X M 2 F 51 Yrs Usual Residence of Deceden 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No 28a-f show MD Baltimore Baltimore with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country or items 23a or 2 r must be notified 21244 7125 Fairbrook Road U.S.A. Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S hours after death Armed Forces? White etc. 1 Never Married 2 Married 1 Yes White Divorced Widowed Yes, Give Year "natural", Examiner 1 Yes 2 No specify 2 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed Baltimore, MD 21215-0036
permit Pages 1 and 2 should be filed within 72 hou
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nat
intury or other transmarite event, the Medical Exa during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Residential Handyman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lea Alfred Harding Patsy Pence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Pibulsiri/sister 2100 Greengage Rd., Balto., MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 2 Cremation 3 .08-29**-**06 Beltsville, MD Chesapeak Cremator Other Specify Donation 5 Signature of Funeral Service Licenses 22. Name and Address of Facility Cafa/Stephen D.Lohrmann, PA GreenPastures Dr. Balto Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Heroin intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Lisease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical X UNPENDED attending physician or use as the burial AMENDED item#23a.PII.27.28a-f.perME.g859.9/1/2006 TT Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death 2 Month Year past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 V Unknown Cocaine use Completed certificate has been s ector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 No death? 1 🗸 Yes 2 No 25. Was case referred to medical To the Hospital or Attending Physician: 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> DOA Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 Other: Scene After this ٩ 1 🗸 Yes 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28d Describe how injury occurred 28c. Injury at Work? Certification: Natural Director: A in by the f 1 Yes 2 No 5 Pending 24 hours after death Fnd 8/23/2006 Fnd 5:53 am unk 2 Accident Investigation Location (Street and Number or Rural Route Number, City or Town, State) 7251 Fairbrook Road 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide determined To the Funeral found at home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHIVIH 17 Rev 1/2001

OCME 2006

State

Assistant Medical Examiner

32 Registrar's Signatur

once 30. Name and address of person who completed cause of death (Item 23a)

2006

Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year)
AUG 3 0

O.C.M.E

111 Penn Street, Baltimore, MD 21201

August 23, 2006

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	,	Certif	ficate of	Death			Reg. No.	20	006	5 27	36
Physician/ Medical Examiner  Josephine  Bev								2. Date of De Month	Day	Yea		3. Time of Dear	th
meulcai Exam	illei	Josephine 4a. Facility Name (if not institution	Be a	verly_		Hi. 4b. City, Town, or	nes	August 2		6 . County o	of Death	1850 hrs	
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Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs, last	birthday)	If Under 1 Yea	r If Under	24Hrs. 8. Date of I	Birth(MM/	DD/YYYY		place (State or	
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221. hould then ond Men is mar	2	19a. Informant's Name/Relationsh	iip (Type, Print )		19b. Mailing	Address (Stree	et and Number	er or Rural Route No	ımber, Cı	ty or Towr	n, State, 2	Zip Code)	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene fant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once		Arlene Saunde	ers-Mothe					Ave, B					15
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Baltimore, Department of Hee Important: If ite		4 Donation 5 Other Spe		Metr	o Cre	matory	Ind	8/31/06	;   I	3alt	imo	re, Md	Į
Baltimo permit Page Department ( Important: injury or oth		27. Signature of Funeral Service L	N.		22. Na	ame and Address	of Facility	tve, Bal			7	2121	_
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/Medical	9 E	fallure. List only one cause of immediate Cause (Final disease	on each line. a. Atherosclerotion					. ,	,	,	17	Between Ons Death	set and
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8760, ficate be executed g physician and s the burial - transi	//Medical	IF FEMALE:	AMENDED										
	Z	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outc			al death 3	Ectopic p	regnancy		l. Date of a Month	delivery Da	y Ye	ar
Box 68 e death certi the attending ed for use as	siciar	1 Yes 2 No 9 ✔ Unkr		at time of death		er (Specify)			İ				
O. B. It the de by the	ا€ا	Part II. Other significant condition	9 Unknown	ath but not resul	Iting in the ur	nderlying cause o	iven in Part	1 23e Did	tohacco i	ise contrib	ute to th	e cause of dea	th?
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Division of Vital Records, lal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Ë	27. Manner of Death 1 ✓ Natural 5 Pandi	28a. Date of Ir (Month, Day		b. Time of In	jury 28c. Injur	y at Work?	28d. Describe	how inju	ry occurre	d		
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			For State Registrar	State of M	laryland	d / Depa <i>Ce</i>	artmer <i>rtifica</i> i	nt of H	ealth a	and M	lental Hy	giene Reg. No.	006	273	868
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9000	ours after draft, or Item	by	1 ☐ Never Married 2 ☐ Marr 3 ※ Widowed 4 ☐ Divorced	Armed Forces' ed 1 ☐ Yes 2X If Yes, Give Year or Dates:			If Yes, spe		n, Mexicar Specify:		ecify Yes or No Rican, etc.)		Black, White,	etc. Lack	
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Exam or interest and iffed at	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed)  College (1-4or	· ·	lite.	kind of wo DO NOT u	ork done d se retired	<i>furi</i> ng mos )		ing Vorker		of Business/In		
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Baltimore,	t. Partmer	,		pecify)	Ce	metery, crei	Fore	est V		9-1-		Owir	ion - City or To		I.
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	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	EPS	ence of):								Onset and	
w.	% <b>4</b> 2	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	·										
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Or the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	déath 3[	Ectopic p Other (sp					230	1. Date of delive Month	,	Year
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Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			Check only		TU-11-2-	7	
Division of Vital Records,	To the Hospital or Attending Physician: which 24 hours after deals the Funaral Director: After this certific completely filled in by the funeral director,	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of Inju (Month, Da	ury 2	R/Outpatier 28b. Time of Injury		28c. Injury Work	4 🗀 140		me 5 Resi 28d. Describe		Other (Specif)	()	
Divis	Hospital or Attending I 24 hours after death. Funaral Director: After 4ely filled in by the funer	Certification:	3 Suicide 6 Could r 4 Homicide determi	ned 28e. Place of in building, e	tc. (Specify)						City or To	wn, State)	lumber or Rura		ber,
	he Hosp n 24 hou he Funai oletely fill	edicai	29a. Certifier (Check only one)  Certifyin Medical I	g Physician: To the best Examiner: On the basis of and manner st	of examination	rledge, death on and/or in	occurred vestigation	at the tim , in my op	e, date an inion, dea	d place, th occurr	and due to the ed at the time,	cause(s) an date and pl	d manner as st ace, and due to	ated. the cause(s	;)
	To the Vithin 2 To the Complet	Σ	29b. Signature and title of certifier	in Ball	Λ	17		License		291			igned (Month,		06
•	À		30. Name and address of person of MANISHA BAI	who completed cause of	death (Item :	23a) (Type,	Print)	560	1	10	CH 6	2 0 1/	ENI		239
	Sta Registr	te	31. Date filed (Month, Day, Year)  AUG 3	2006 32. Fegistr	rar's Signatu	NO LE	ed .	<i>,</i>	DHL	. 11 17	IUKE 1	MAK	YLAN.	1) 41	237

State of Maryland / Department of Health and Mental Hygiens 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Norman Lee Harding August 25 4:14 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's 6. Sex 1 → M 2 □ F If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 214-18-8546 85 Yrs. Nov. 1, 1920 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at Director 1 Yes 2 XNo MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itema 23a 10037 Superior Avenue 20723 death USA Funera 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No 1942 - If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, e filed within 72 hours after all Hygiene. al Hygiene. I other than "natural", or Iter Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry University of College (1-4or 5+) Elementary/Secondary (0-12) 7th Electrician Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be fill Health and Mental H tem 27 Is marked ott Be Joseph E. Harding Maggie Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a fimportant: If Item 27 Is any injury or other tra Alice Harding/Wife 10037 Superior Avenue, Laurel, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ivy Hill Cemetery 8/28/2006 Laurel, MD 22 Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Lighnsee 313 Talbott Avenue, Laurel, MD M00160 reden aure & an 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Carcinoma Lung disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that is Examiner Due to (or as a consequence of): anding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. F ed by the a 1 Yes 2 No 9□ Unknown 9 Unknown cete has been signed in page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Coronary Artery Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 **□**No 1 ☐ Yes 21 No After this certification funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1-X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident the the within 24 hours after dea To the Funeral Director completely filled in by th 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D24283 August 25, 2006 241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Yusef, VMD 13631 Baltimore Avenue, Laurel, MD 20707 31. Date filed (Month, Day, Year) 2. Registrar's Signature AUG 3 0 2006

Registrar

State of Maryland / Department of Health and Mental Hygieney 27370 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** August 28, SARA ALICE HYATT 2006 2:00 рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Health & Rehab. Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Adopths | Davs | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 420-18-4564 Director 85 Yrs. Alabama Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☐ No Directo Maryland Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 8381 Gatewood Drive 20794 Itema 23a U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 22 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2X No Completed by Specify: 3 Widowed 4 ☐ Divorced "natural" White the Mudical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Grade 12 Homemaker Own Home othert 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental ? William Campbell Louie Chancey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Alice Green daughter 8381 Gatewood Drive Jessup, Maryland E 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ivy Hill Cemetery Sept 1, 2006 Laurel, 21. Signature of Euneral Service Licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. / M00770 313 Talbott Avenue Laurel, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Athero Sclevolic **Physician** (andwoves Cular disease or condition resulting in death) /Medical Examiner wome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed av cinoma Dladder Unnay resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 P No
9 Unknown 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò been signated by the state of t 3 Probably 4 Unknown Completed 24a. Was an 24b. Were aulopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 2 No cate has l page 2 s autopsy performed? certificate 2 2 No 1 Yes Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital: Other: Medical Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 ANatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Director: / 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause s and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D30641 Cum 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201-109 Back RIVER Neck Road Sabapalhi Kamesh 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

DHMH 17 Rev 1/2001

AUG 3 0 2006

			1 - For State Registrar	State of N	laryland / [	Departm Certific	ent of He ate of D	ealth and leath	Mental Hy	ygiene Reg. No.	006	27371
	Physic /Medi		1. Decedent's Name (First, Mid William Henry Hir	dak					2. Date of D Month August	Day	Year	3. Time of Death 7:55am M
	Exami		4a. Facility Name (If not institution 3113 Louise Avenutes. Social Security Number	e	ge (In yrs. last bir	Bal	timore C	ocation of Deal  ity  If Under 24 Hrs		Bal	timore	
	Funeral Director		215 12 9385 Usual Residence of Decedent	1011 102		Yrs. Mon		Hours Min.		lav. Year)	1 00	imore, Maryland
	Maryland a-f show	ctor	10a. State 10b. Count  Maryland Baltin	ore City	10c. City, Town							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	eath with the s 23a or 28 num be no	Funeral Director	10e. Street and Number 3113 Louise Avenue			10f 2	. Zip Code 1214			USA	n of What Co	,
980	ours after de ei', or item Examiner in	þ	11. Marital Status  1 □ Never Married 2 □ Ma  3 ☑ Widowed 4 □ Divorce	If Yas Give	? No	If Yes,	specify Cuban,	panic Origin? (S Mexican, Puerl Specify:	specify Yes or N to Rican, etc.)		Race - Ame Black, White Decify: Wh	nican Indian, e, etc. ite
Maryland 21215-0036	d within 72 hours after death with the Maryland Jiene. rthen "naturel", or Iteme 23a or 28a-f show the Medical Examinar must be notified at	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	ont's Education est grade completed)  College (1-4or	5+)	Decedent's (Give kind on life. DO NO		on ring most of wo	rking		of Business/	Industry
yland 2	be filed tal Hygod othe event,	To Be Co	17. Father's Name (First, Middle John Hudak		USL	e Guo	11		me (First, Middle abeth Pric	e, Maiden Su	nore Or mame)	ioles
	is 1 and 2 should of Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relation Linda E Hudak  20a. Method of Disposition	ship (Type, Print)	31	13 Iori			ore, Mary Date	land 212		
Baltimore,	it. Page intment o intent: if njury or		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other ( 21. Signature of Funeral Service	Specify)		of Fair	th Cem. A	Ligust 30	2006		nore, Mar	,
B	perm Depa impo impo any i		23a. Part1. Enter the disease, o shock, or heart failure. Lis	or complications that cause of only one cause on each I	d the death. Do n	Lassal 7/m1 I	n Funera Relair Ro mode of dying,	of Facility I Home II pad Baltir such as cardiac	nc Tore, Mar or respiratory	vland 21	236	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. SEVS	s a consequence of							Onset and Death
68760, 6	tificate be executed g physicien and as the burial-transit	sal Examiner	Sequentially list conditions, if any, reading to intribudate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. PNEU	MNA MUN M is a consequence of							3-4 weeks
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ords, P.	w requires that been signed b should be deta	ted by Pr	Part II. Other significant condit				ig cause given i	in Part I.	23e. Did t	1		the cause of death?
al Reco	n: The law r licete has be rr, page 2 sh	Completed by	DYSPIBNOVA						24a. Was auto perfo	an 24 psy primed? 2 2 No	4b. Were aut prior to c death? 1 ☐ Yes	opsy findings available ompletion of cause of
Division of Vital Records,	To the Hospitel or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	lon: To Be	25. Was case referred to medical examiner? 1 Tyes 2 No  27. Manner of Death Natural 5 Tyendi	Hospital: 1 [ fnpatie 28a. Date of Inju (Month, Da		ime of	DOA Other: 28c. Injury at Work?	4 ☐ Nursing H	th (Check only of ome 5 Resi 28d. Describe	dence 6 🗆		ify)
Division	tel or Attandesters after desti el Director: ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could	mined 286. Place of Inj	ury - At home, far c. (Specify)	M 1 Yes 2 No  At home, farm, street, factory, office 28f. Location (Street and Number of R					umber or Rui	ral Route Number,
	the Hospi thin 24 hou the Funer mpletely fill	Medical	29a. Certifier (Check only one)  2 ☐ Medical	ng Physician: To the best I Examiner: On the basis o and manner st	t examination and	vor investigat	ion, in my opini	on, death occu	rred at the time,	date and pla	ce, and due	to the cause(s)
)	1071		· Rungy	1 MMg	leath (Item 23a) (		29c. License na		4	29d. Date sig	-	Day, Year)
	Sta	te	30. Name and address of person 56 V LUCU	200 32. Registr	D , BM	TIMUN	& MD	7123	5			
	Registr	ar	AUU (	0 2000	Sold Charles Stage	A Comment						

William HUDAK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 27372

		1 - State Registrar		•	Certificate of	of Death	R	eg. No.	
		1. Decedent's Name (First, Middle,	Last)				2. Date of Deat	th	3. Time of Death
Physi /Med		Arthur M. Hei	Lman				Rugust	23 2006	8:09 B.M.
Exam		4a Facility Name (If not institution,	give street and number)		4b. City, Tow	n, or Location of De		4c. County of Death	1
		St. Lanes He	outh Care		La1+	imore	9		
Funera	1		S. Sex 7. Age (	'In yrs. last		ear If Under 24 H		9. Birth	pface (State or Foreign
Directo		219-18-8577	1 <b>2</b> 5M 2□F	79	Yrs. Months Da	ys Hours M	in. (Month, Day, Dec. 17	Year) Cou	intry)
70		Usual Residence of Decedeni					Dec. 17	, 1920 Fell	nsylvania
ylan		10a. State 10b. County	1	Oc. City, To	own or Location				10d. Inside City Limits
Mar.	Į	Maryland Baltin	nore	Caton	sville				1 ☐ Yes 2 🖾 No
with the Maryland a or 28s-f ehow be notified at	Director	10e. Street and Number		00001	10f. Zip Coo	ie	1	Og. Citizen of What Cou	intry?
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural; or items 23a or 28s-f show ont, the Madical Experiment be netilised at		719 Maiden Cho		,	2.1	228		TTOA	•
ter deat	Funeral	11. Maritaf Status	12. Was Decedent Eve				(Specify Yes or No- erto Rican, etc.)	USA 14. Race - Amer	ican Indian.
after or its	교	1 Never Married 2 Marrie	Armed Forces? d 1 □XYes 2 □ No				erto Rican, etc.)	Black, White	
030 urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWII	1 ☐ Yes 2 🛣	No Specify:		Specify: Wh	ite
15-003	ted	15. Decedent's	Education		Sa. Decedent's Usual Oc	cupation		16b. Kind of Business/li	ndustry
Pin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)		(Give kind of work do life. DO NOT use re	one during most of v tired)	vorking		,
22 d with	E	Lional Nary 70000 Houry (0 12)	4	S	heet Metal	Superviso	or B	altimore Ga	s & Electr
Maryland 21215-0036 to 2 should be filed within 72 hours all tith and Mental Hygiene. 27 1e marked other then "natural; or traumatic event; the Madical Exercit	Be	17. Father's Name (First, Middle, L.	est)			18. Mother's N	lame (First, Middle, A		
land be sental rked o	10 E	Arthur Heilman				Cont		c.	
aryla should nd Mer marke umaric	-	19a. Informant's Name/Relationshi	o (Type, Print)	. 1	9b. Maifing Address (Str	eet and Number or	nerine Sen Rural Route Number	City or Town State Zi	n Code)
	1	Elaine Heilman	Wife						
0		20a. Method of Disposition		20b. Place	719 Maiden of Disposition (Name of		Date 134	Catonsvil Coc. Location - City or T	1e, MD 2122
MOF Pages nent of t		1 ☐ Burial 2 XCremation :	☐Removal from State	ceme	tery, crematory or other	place)			
Baltimo permit. Pago Department Important: if		4 ☐ Donation 5 ☐ Other (Special Signature of Further and Service Li		Metro	Crematory		6/2006	Catonsville	, Maryland
Balti permit. Departr Imports		21. Signature of Bulleral Service Li	cens		Funera	dress of Facility 5 t	Catonsvi	nton Schwab	Witzke
		Ma	( all		1630_E	dmondson	Avenue: Ca	atonewille	MD 21228
		23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused the nly one cause on each line.	e death. D	o not enter the mode of	dying, such as card	ac or respiratory arre	st,	Approximate Interval Between
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/Medical Examiner		resulting in death)	Due to (or as a co	onsequenc	e of):				
Cxamine	. /	Secuentially list conditions.	b						
72 = 27	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequenc	e of):				
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SO,		resulting in death) cast	Due to (or as a co	onsequenc	e of):				
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x 687 ertificate ling phys	Medical	IF FEMALE:							
Box 6 eath certif		23b. Was decedent pregnant	23c. If yes, outcome of p		th 3 ☐Ectopic pregna	D.C.		23d. Date of deliv	ery
death of attended for us	<u>c</u>	in the past 12 months? 1 □ Yes 2 □No	4 Pregnant at tim		5 ☐ Other (specify			Month	Day Year
P.O. Box B.O. Box Sthat the death ce and by the attendi	Physician	9 □ U⊓known	9□ Unknown						
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Cord	Completed						24a. Was an	24h Word auto	anay findings available
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Sic Itsnd Heath tor: ,	cat	2 Accident investiga 3 Suicide 6 Could no	bo			Yes 2 No			
Division i or Attending after death. Director: After	Certification:	4 Homicide determin	28e. Pface of fnjury building, etc. (S	- At home, Specify)	farm, street, factory, office	C <del>0</del>	28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number.
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Division of To the Hospital or Attanding F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical	(CHOCK ONLY S MIGGICALE)	Physician: To the best of maminer: On the basis of exa	amination a	ge, death occurred at the	time, date and place opinion, death occurrence	ce, and due to the car	use(s) and manner as s	tated.
the hin 2 the nplet	Med	3.10)	and manner stated						
To To con	-	29b. Signature and title of certifier	^	1	29c. Lice	ense number	11 1	d. Date signed (Month,	
		Junan G	posico 1	~^7		3+1 C	M	100st 23,	2006

State Registrar

JUSAN ESPOSITO
31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan Esposite 900 Caton Avenue Baltimace Ma 32. Registrar's Signature

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Intla KofeR Month Ohr August 25, 2006 10:45 PM /Medical 4a Facility Neme (If not Institution, give street end number 4b. City, Town, or Location of Death Examiner 4c. County of Deeth 6580 Loch Raven Boulevard Baltimore Baltimore 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Days Months Yrs Director 92 112-07-4661 Oregon 1914 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Merylend Depertment of Heelth end Mentel Hygiene. Impropriant: If Rem 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event. The Medical Eventuals. 10e. State 10b. County 10c. City, Town or Location d other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6580 Loch Raven Boulevard Funeral 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by Specify. 3 □ Widowed 4 □ Divorced White Year or Dates 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education
(Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Federal** Systems Analyst Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Intlekofer Agnes Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Betty Rose Intlekofer/Wife 6580 Loch Raven Boulevard Baltimore, MD 21239 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 8/26/06 Baltimore, MD 21. Signature of Edneral Service Licensee

Coloured by Creyon 22 Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 Edward A Gregorchik 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner The lew requires that the deeth certificate be executed ettending physicien enclifor use es the buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) been signed by the should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? s certificate has b director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 ☐ No this Director: After this in by the funerel 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Certification: 28d. Describe how injury occurred Injury at Work? 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours ef To the Funeral DI completely filled in edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) and manner as steted.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 6701 N. Charles 57. Josep Idams Towson AUG 3 0 31. Date filed (Month\_Day, 32. Régistrar's Signature State MELTER Registrar

DHMH 16 Rev 6/95

**ORIGINAL** 

			1- For State of Maryland / Department of Certificate			ene 2006	27374
	Physic		1. Decedent's Name (First, Middle, Last)  Lan Leglen		2. Date of Death Month Aug 29,	Day Yea	3. Time of Death 4:54A
	/Medi Examir			wn, or Location of Death	rag 25,	4c. County of De	4.547
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	Funeral Director		231 44 2000 AAA 70 Yrs.	ays Hours Min.	8. Date of Birth (Month, Day, ) Jan 23, 19	9. B 36	irthplace (State or Foreign Country) VA
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	****	<del></del>		10d. Inside City Limits
	Man	to	MD Anne Arundel Brooklyn				1 ☐ Yes 3√∑ No
	th the	Director	10e. Street and Number 10f. Zip Co	ode	100	g. Citizen of What (	Country?
	ath w			225	_	US	6A
	er de Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 □ No	t of Hispanic Origin? (Spe Cuban, Mexican, Puerto I	city Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
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Maryland 21215-0036	2 should be and Mental is marked raumatic ev	-		treet and Number or Rura		City or Town, State,	Zip Code)
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Balt	permit. Pages Department of Important: If I any Injury or once.			ddress of Facility eral Home ClenA	Burnie, MD	21061	
Г			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of shock or heart failure. List only one cause on each line.				Approximate Interval Between
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-	ospital hours unerai ly filled		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the	e time, date and place, a	nd due to the caus	e(s) and manner a	s stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	fedical	one) and manner stated.	ny opinion, death occurre	d at the time, date	and place, and du	e to the cause(s)
	vit Con	Σ	29b. Signature and title of certifier 29c. Lic	cense number	29d.	Date signed (Mon	th, Day, Year)
	6		20 Name and olderess	14177+		0. 74.	06
	9		30. Name and address reson who completed cause of death (Item 23a) (Type, Print)	undara Ra	Yala	den 1 1	w 1/11
	Sta		31. Date filed (Monto, Day, Year) 32. Registrar's Signature	11111	1 000	, ~ [(\d_{-1})	y Lill
	Registr	ar	AUG 3 0 2006 Brown 18 Species				

DHMH 17 Rev 1/2001

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aumatic ev	Jo I	William F. Vord	demberge			len R. Andre		
raum		19a. Informant's Name/Relationship			ling Address (Street and Nu			Zip Code)
other trau		Gary Seibert  20a. Method of Disposition	Friend	d 502 20b. Place of Disp	Hillen Road;	Towson, MD	-	**
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the funeral director, page 2 should be detached for use as	edical Certification; To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 menths?  1	Due to (or as a OLO)  Due to (or as a old)  23c. If yes, outcome of the pregnant at the pregna	of pregnancy consequence of):  of pregnancy consequence of):	Dectopic pregnancy Other (specify)  26. Pla  26. Pla  27. Pla  27. Pla  28c. Injury at  Work?  1 yes 2  reet, factory, office  th occurred at the time, date investigation, in my opinion, of  29c. License numbe	art I. 23e. Did  24a. Wa autropen  1   Yes  ace of Death (Check only  Nursing Home 5   Res  28d. Describe  28d. Describe  28f. Location City or Trowson  and place, and due to the death occurred at the time	23d. Date of del Month  23d. Date of del Month  24b. Were au prior to death? 2 No 3 Pr  24b. Were au prior to death? 1 Yes  3 Pr  24b. Were au prior to death? 1 Yes  3 Pr  24b. Were au prior to death? 1 Pres  3 Pr  4 Cause (6) Other (Special County, State)  2 Cause (s) and manner as and due and place, and due 29d. Date signed (Month)	livery Day Year  to the cause of death?  robably 4 Unknown  utopsy findings availate completion of cause of the cause of t

Months

Joseph S. Koscinski

7. Age (In yrs. last birthday)

Gilchrist Hospice Center

Certificate of Death

4b. City. Town, or Location of Death

Days

 $\sim$ 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

32. Registrar's Signature

For State Registrar

5. Social Security Number

29b. Signature and title of certifier

Amon 31. Date filed (Month, Day, Year)

Charles

AUG 3 0 2006

7

State

Registrar DHMH 17 Rev 1/2001

**Physician** 

/Medical

Examiner

**Funeral** 

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

27376

11:15 a.n<sup>M</sup>

3. Time of Death

Baltimore

U.S.A.

US State Department

Sykesville, MD

Approximate fnterval Between Onset and Death

14. Race - American Indian, Black, White, etc.

Specify:

16b. Kind of Business/Industry

20c. Location - City or Town, State

23d. Date of delivery

Dav

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Year

Month

Birthplace (State or Foreign Country)

White

Connecticut

10d. fnside City Limits

1 ☐ Yes 2 No

Reg. No.

Day

August 27, 2006

4c. County of Death

2. Date of Death

Month

Baltimore

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

D58307 Aug des St Britmone us

State of Maryland / Department of Health and Mental Hygiene 2006 27377 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month -illian 1-00-1700 PM /Medical 08 2006 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore City UNIVEYSITY OF 5. Social Security Number Many and Medical Center Baltmore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6 Sex **Funeral** 7. Age (In yrs. last birthday) Date of Birth (Month/Day Year) 22 Birthplace (State or Foreign Lountry) 1 □ M 2 🕱 F 354-16-3316 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 ie marked other than "nstural", or items 23a or 28a-f eho: other traumatic event, the Mcdical Examinar must be notified at MD Director Montgomerv Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3118 Gracefield Rd. #208 20904-United States Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 閏 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Completed by Specify: 3 K Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Education I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Religious Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Health and Mental H fitem 27 le marked ott Be Charles Herbert Jones Fern Azelle Storm ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Halcyon Ahearn/Daughter 65-F Ridge Rd. Greenbelt, MD 20770-Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Pages 1 Chesapeake Crematory Inc. 6 permit. Page: Department of Important: If i any injury or once. 1 ☐ Burial 2 SCremation 3 ☐ Removal from State = 5 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Rapp Funeral & Cremation Services M00382 tiph & John armin 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Du monay insufficiency /Medical Due to (or as a consequence of): **Examiner** Ostomullitis Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as onsequence of): The law requires that the death certificate be executed use as the burial-transit ar ole ia the attending physicien and resulting in death) Last ue to (or a co quence of) P.O. Box 68760, Lumbar fracture Physician/Medical OSteo porotic IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death Day 5 Other (specify) detached 9 Unknown 9□ Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Completed 1 ☐ Yes 2 € No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 24a. Was an autopsy performed? Division of Vital 1 Yes 2 No To the Hospitel or Attending Physicien: : After this certifical funeral director, 25. Was case referred to medical Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No Hospital: 2 ER/Outpatient 1 Impatient 3 DDA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2\_ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) leen A4 4135 MIG 112/2006 Q 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eenag reene steet 31. Date filed (Month, Day, Year) State 32. Rimistrar's Signature AUG 3 0 2006 Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 200627379 1 - State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 27, 5:25 p RUTH ELIZABETH LOCKARD August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 84th Avenue New Carrollton Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 💢 F 81 1925 New Jersey Director 158-16-8372 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location th and Mental Hygiene. ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1X Yes 2 □ No Director Mary land Prince George's New Carrollton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5807 84th Avenue Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after ☐Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 3 X Widowed 4 ☐ Divorced Year or Dates: ed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) Own Home 4 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F Is marked of Walter S. Titterington Mary E. Armstrong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann K. Guy - Daughter/POA 6148 Kara's Walk, Elkridge, Maryland 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 9/1/2006 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, Virginia \* 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4739 Baltimore Ave., Hyattsville, MD 20781 Manuel Approximate Interval Between Onset and Death 23 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** months ementia /Medical Due to (or as a consequence of) Examiner ancer 100 MICHIE Sequentially list conditions, if any, leading to immediate cause. Enter the Jarryng Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No certificate 1 Yes 26 Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 | Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 VadL 31. Date filed (Month, Day, Year) State AUG 3 0 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200627380 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician John T. Lawrence 7:10p Aug 23, 2006 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner Baltimore** 833 West Pratt Street - Apt 215 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 ☐ F Yrs. 237-40-0698 Director Aug 22, 1929 No. Carolina Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 □ No Maryland N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 833 West Pratt Street - Apt 215 21201 U.S.A. Items 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. and telms 23 is marked other than "naturel", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Colonial Motor Company Freight Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willie Lee Lawrence Freelor Lawrence 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1635 Frederick Avenue Baltimore, Maryland 21223 Dia Spence Daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ò 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 08/29/06 Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery of Funeral Service Licen 22. Name and Address of Facility 21. Signatuse Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part 1. Enter the dispase, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Ostat **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown s been signed by t ? should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA : After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. investigation 1 Tes 2 No 2 Accident the within 24 hours after deal To the Funeral Directors 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check or one) Medical Examiner. the 29b. Signatu and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

Registrar DHMH 17 Rev 1/2001

8

State

30. Name and address of person

31. Date filed (Month, Day, Year)

AUG 3 0 2006

ho completed cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature

		1 - For State Registrar	State of Maryland		rtment of H			giene 006	27381
Physic /Med		1. Decedent's Name (First, Middle, Last)  PACE. H. N	AYES				2. Date of De Month AUGUS:T	Day Yea 24 200	/ / / / / / / / / / / / / / / / / / / /
Exami		4a. Facility Name (If not institution, give s HARBOR /4056	street and number)		4b. City, Town, or BALTO	Location of D		4c. County of D	eath
Funeral Director	100	5. Social Security Number 6. Sex 1 Land Security Number 1 Land Secur	M 2017 7. Age (In yrs. last	birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bir (Month, Da	th iy, Year) 9. 8 1, 1911	Birthplace (State or Foreign Country)
Maryland -f ehow	tor	10a. State 10b. County	10c. City, T		ation BALTIME	RO			10d. Inside City Limits 1 ✓ Yes 2 ☐ No
with the a or 28a	Director	10e. Street and Number	rne Ave		10f. Zip Code	1230		10g. Citizen of What	
ified within 72 hours after death with the Maryland Hygiene. Hygiene. Ither then "natural", or Itema 23a or 28a-1 show ant, the Marical Executing with the mailtied at	Funerai		12. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2 No If Yes, Give		* '	spanic Origin n, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	14. Race - Al Black, W	merican Indian, hite, etc.
in 72 hours	Completed by	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade)	reation 1- completed)	6a. Decede	ent's Usual Occupa ind of work done of O NOT use retired	ation during most of	working	Specify: L	ss/Industry
filed withi Hygiene. ther than	e Comp	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+)		Homem	AKER	Name (First, Middle	Ho Me	
ges 1 and 2 should be filed within to Health and Mental Hydiene. If item 27 is marked other than or other traumatic event, the Mental Hydiene.	To Be	Phillip Lins  19a. Informant's Name/Relationship (Ty)	na Print)	19h Mailing	Addraga (Stragt a	ESTe.	lle Brow	חי	. Tie Codel
		TINA BORAM		5830	WeSTWO	ope m	DALL	er, City or Town, State  D MO 2 ( )  20c. Location - City	6 6
permit. Pages 1 and Department of Health Important: If Item 27 eny injury or other tronce.		20a. Method of Disposition 1 ☐ Burial 2☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	etery, crema	tion (Name of atory or other place	(S)	178/06	BALTO M	or rown, State
permit. Page Department of important: If eny injury or		21. Signature of Funeral Service License Fuel M. S	Telen	P	Name and Addres Jul 5   ell 52   nay	A Fund	o. BAlto.	BALLO M PA MO 2103	4
Physician		23a. a. 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death. Decays on each line.	Do not enter	the mode of dying	g, such as car	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)  Sequentially list conditions,	Due to (or as a consequence Co. FON A	ce of):	artery a	disease			75 YEARS
ate be executed hysicien and the burial-transit	Examiner	n any, reaumg to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  A Y Part  Due to (or as a consequence)	ens ion					754 TARS
the at	edicai		-		***************************************			1	
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours effer death. Funeral Director: After this certificate has been signed by the attending placement in by the funeral director, page 2 should be detached for use as the second secon	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de: 4 □ Pregnant at time of death 9 □ Unknown	ath 3□E	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
quires that the de	by	Part II. Other significant conditions con	A s	g in the unc	derlying cause give	n in Part I.	23e. Did t		to the cause of death?  Probably 4 □Unknown
rsician: The law requires certificate has been significated by Should to	Completed						24a. Was autop perfo	osy prior t rmed? death	
ysician: is certific director,	To Be	25. Was case referred to medical examiner?	ospital: Linpatient 2 ER/	Outpatient	3□ DOA Othe		Death (Check only only only only only only only only	nne) dence 6 □Other (Sp	pecily)
To the Hospital or Attending Physician: The Within 24 hours efter death. To the Funeral Director: Atter this certificate hat completely filled in by the funeral director, page	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		b. Time of Injury	28c. Injury Work	at ? ′es 2 ∐No		now injury occurred	
To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the it.		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)				City or Tox		
the Hosp in 24 hou the Funel pletely file	ledicai	one)	ician: To the best of my knowled ler: On the basis of examination and manner stated.	dge, death o and/or inve	stigation, in my op	inion, death o	ace, and due to the courred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
Tot Com	2	29b. Signature and title of certifier	Ms		29c. License			29d. Date signed (Mo	
50		30. Name and address of person who co	mpleted cause of death (Item 23:	a) (Type, P	rint)		ST 0.11		1,20%
St Regist	ate	31. Date filed (Month, Day, Year)  AUG 3 0 200	32. Agistrar's Signature	300	M. a	(INVIOLE)	. ST Balk	WO 3,242	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23a, pt.II per doc 8859 9-27-06 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 27382 1 - State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 7:30 PM M August 27, 2006 Chester Eric Munn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10314 Malcolm Circle Cockeysville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/26/1961 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours Min. 1**⊠**M 2□F 45 Yrs NY 090-56-3470 Director Usual Residence of Decedent the Maryland Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No MD Baltimore Cockeysville 289-1 Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21030 10314 Malcolm Circle USA or items 23a death Funeral 12. Was Decedent Ever in U.S. Amed Forces? ↑BYes 2 □ No If Yes, Give Year or Dates! ↑ \$3 - \$7 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Maryland 21215-0036 18⊈Yes 2□No Specify:PuertoRican Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry American Airlines Elementary/Secondary (0-12) College (1-4or 5+) Flight Attendant 12 other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any injury or other treumatic event, sone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Chester Munn Maria Perez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Perez/Mother 3535 Long Island City Astoria, NY 11106 Baltimore, N 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Aug 30 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2006 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Alcohol Cirrhosis 8717 Green Pastures Drive Baltimore, Maryland Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) twised immune deficience Physician Years /Medical o (or as a consequence of): Due Examiner cause thatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of) Box 68760 that the death certificate be Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant /WHN 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by The law requires page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Acquired Immune Deficiency Syndrome 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Vital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death Check only one examiner Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this After this funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1. Natural 5 Pending М 1 Tes 2 No investigation hours after death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 T Homicide within 24 hours a

To the Funarel C To the Hospitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D24170 UXI 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) Hospice 838 Entawist Baltimore MD E: 75.0 31. Date filed (Month, Day, Year) Registrar State AUG 3 0 2006 Registrar

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			For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of H			iene g. No. 2 (	006	2738
	-		Decedent's Name (First, Middle, La	st)				2. Date of Deat	h		3. Time of Death
	Physici /Medi		Donna Marie	Mvers				AUGUST	28, a	≥ጲ෦ඁ෯ඁඁ6	9:45 AM
)	Examir		4a. Facility Name (If not institution, given Saint Joseph	e street and number,		4b. City, Town, o		eath ISON	4c. County	of Death	imore
	Funeral		Social Security Number 6. 5	,	je (In yrs. last birthday)	If Under 1 Year	If Under 24		Vanel	9. Birthp	lace (State or Foreign
	Director		219-58-5291	□M 2∏ F	55 Yrs.	Months Days	Hours N	Min. (Month, Day, Aug. 28	,1950	Cour	MD
	P >		Usual Residence of Decedent  10a, State 10b, County		100 City Town and						Od Inside City Limite
	aryla shov	-	10a. State 10b. County		10c. City, Town or Lo	ocation				,	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the Marylan 28s-1 show	ecto	PA York		Fawn G						
	within 72 hours after death with the Maryland ene. thsn "naturel", or Items 23a or 28a-1 show ne Madical Exp. after rougle position	Funeral Director	10e. Street and Number			10f. Zip Code		3	0g. Citizen of	What Cour	ntry?
	s 23	erai	1077 Graceton R	oad 12. Was Decedent	Francis II S 40	1732		2 (8	- Y	USA ce - Americ	an Indian
	ltem Item	un.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces		If Yes, specify Cuba	an, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		ck, White,	
36	rs aft	by F	3 ☐ Widowed 4 🔀 Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates:	140	1 ☐ Yes 2 No	Specify:		Specif		
21215-0036	2 hou	pa	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation		16b. Kind of B		hite dustry
15	n n	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)	(Give	kind of work done DO NOT use retired	during most of d)	working			,
212	iene Trans	Eo	12	College (1-4or		cretary			Ват	nking	
	Hygid other	Bec	17. Father's Name (First, Middle, Last	)		010001)	18. Mother's	Name (First, Middle, I			
<u>a</u>	should be filed within and Mental Hygiene. marked other than imatic event, the Market th	ToE	Joseph Eckert				M	ary Cave			
Maryland	is 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene, term 27 is marked other than "naturel", or Items 23a or 28a-1 show other traumatic event, the Medical Examiner rount be notified at		19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address (Street	and Number o	r Rural Route Number	City or Town	, State, Zip	Code)
	and 2 Balth n 27 i		Deana Sullivan	Daught	er 1077	Gracetor	n Road,	Fawn Grov	e, PA 1	17321	
Baltimore,	permit. Pages 1 and 2: Department of Health at Important: If item 27 is any Injury or other tracents.		20a. Method of Disposition 1 TBurial 2 Cremation 3	Demouslésses State	20b. Place of Dispo cemetery, crea	osition (Name of matory or other place	ce)	Date	20c. Location	- City or To	wn, State
Ē	Pages nent of I ant: If it		4 □Donation 5 □ Other (Speci			n Cemeter	rv 8	/30/06	Randa	allst	own, MD
alt	permit. Departr Importueny Injudice.		21. Signature of Funeral Service Lice	nsee (		2. Name and Addre			Reiste		
8	\$ 2 E E 8		Seefler	- m fe	issus E	line Fune	eral Ho	me Reiste	rstown	, MD	21136
8760,	The law requires that the death certificate be executed by the attending physician and properties as the burial-transit of the detached for use as the burial-transit.	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as SEVERE b. Due to (or as c.	AEGATIVE a consequence of): F'ANCYTO a consequence of): a consequence of):						Onset and Death
.89	ificat g phy as the	edic									
P.O. Box	that the death certificed by the attending I detached for use as	Physician/Me	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	<b>y</b>			ite of delive onth	Day Year
	that		Part II. Other significant conditions	contributing to death t	out not resulting in the u	inderlying cause giv	ven in Part I.	23e. Did tob	acco use con	tribute to th	e cause of death?
Records,	w requires to been signed should be a	d by						1 □ Y€	s 2X No	3 🗌 Prob	ably 4 ∐Unknown
8	w rec	Completed						24a. Was a	n 24b.	Were auto	psy findings available
Re	The lav	E C						autops perforr	y ned?	prior to con death?	npletion of cause of
Vital		0	25. Was case referred to medical				26 Place of	1 ☐ Yes 2 Death (Check only on		1 🗌 Yes	2LJ No
>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 🏋 No	Hospital:	ent 2 ER/Outpatier	nt 3 DOA Oth	or.	ng Home 5 ☐ Reside	1	ner /Snecifi	,1
<b>o</b>	g Ph er thi	n: T	27. Manner of Death	28a. Date of Inju	ury 28b. Time o			28d. Describe ho			/
<u>0</u>	Attending Indeath.	atio	1 Matural 5 ☐ Pending 2 ☐ Accident Investigation		ly Year) Injury		Yes 2 □ No				
Division	al or Atte s after de il Directo id in by th	Certification:	3 Suicide 6 Could not be determined	Zoe. Flace of in	jury - At home, farm, sti c. (Specify)	reet, lactory, office		28f. Location (St City or Town		ber or Rura	l Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	nysician: To the best miner: On the basis of and manner st	of my knowledge, deat of examination and/or in ated.	h occurred at the tir evestigation, in my o	me, date and p opinion, death o	lace, and due to the ca occurred at the time, di	use(s) and mate and place,	anner as si and due to	ated. the cause(s)
	To the within To the Comp	Σ	29b. Signature and title of pertifier	mel	t. ma =	29c. Licens	e number	2	9d. Date signe	d (Month.	Day, Year)
			> Sadyman	111-01	La Iri-O	D 4	1410	A	agust	26	, 2006.
	10		30. Name and address of person who	completed cause of	death (Item 23a) (Type,	Print)					
	10		JOGINDER FY M	EHTA, M.	7601	OSLER D	RIVE,	TOWSON,	MARYL	AND :	21204
1	Sta	ate	31. Date filed (Month, Pay, Year)	nns 32. Regist	ar's Signature	B - A0 -					

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Ma	aryland / Depa <i>Cel</i>	artment of He rtificate of D	ealth and M <i>eath</i>	lental Hyg	giene 200	6 27385
ď	Physici /Medic		Decedent's Name (First, Middle, Las James	<i>v</i>	M	ckiver, Sr	c	2. Date of Dea Month	Day Yea	/ / - /\ M
	Examir		4a. Facility Name (If not institution, give Good Samari Tan	Hospital		4b. City, Town, or L Baltimor	e, MD	21239	4c. County of D	
. 25	Funeral Director	5-2018	5. Social Security Number 239–58–9341  Usual Residence of Decedent	9X 7. Ag	e (In yrs. last birthday)  67  Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da) 8–17-	th y, Year) -1939	Birthplace (State or Foreign Country)  Md.
	Maryland -f show ied at	tor	10a. State 10b. County  Md. NA		10c. City, Town or Lo					10d. Inside City Limits  Y☐ Yes 2☐ No
	h with the 3s or 28s	al Director	10e. Street and Number 5813 Leith Walk	Avenue		10f. Zip Code 21239	9		10g. Citizen of What USA	Country?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene if item 27 is marked other then "natural", or items 23s or 28s-f show or other traumatic avant. The Medical Examinar must be truffied at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	Was Decedent of His If Yes, specify Cuban, 1 ☐ Yes 2 ※ No	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, Ihite, etc. Black
21215-0036	within 72 ho piene r then "natur The Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12th grade	ucation de completed) College (1-4or 5	(Give	dent's Usual Occupati kind of work done du DO NOT use retired)	ion iring most of worki	ng	16b. Kind of Busine Merchant	·
	d 2 should be filed within 7 h and Mental Hygiene 7 is marked other then " traumatic svent, I'va Med	To Be C	17. Father's Name (First, Middle, Last)  James	Donnie	McKiver		18. Mother's Name		Maiden Sumame) McClea	an
Maryland	d 2 shou th and M ?7 is mar trsumati	<b> </b>	19a. Informant's Name/Relationship (7	<sub>урв, Print)</sub> Daught	19b. Maili	ng Address (Street an 2 Kent Ave	d Number or Rura	al Route Numbe	er, City or Town, State	_
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is sny injury or other trat <u>once</u> .		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	20b. Place of Dispo	osition (Name of matory or other place)		Date	20c. Location - City  Baltimore	or Town, State
Balti	permit. Departm Importar sny inju		21. Signature of Funeral Service Licen		22	2. Name and Address	of Facility	Balt	imore, Md. . North A	. 21202
8760,	Physician //Medical Examiner and physician a	dical Examiner	shock, or heart failure. List only of the shock of the sh	a. Pul Due to (or as b. Cor Oue to (or as c. Enc	a consequence of):	Embolis. nale chronic		re pu mo	nam des	Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and ragge 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
	w requires that been signed by should be deta		Part II. Other significant conditions of		out not resulting in the u	nderlying cause given	in Part I.			e to the cause of death?  Probably 4 □Unknown
I Records,	The law requate has been page 2 should	Completed by								
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		1 -	26. Place of Death			
o o	shys this al dia	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		f 28c. Injury a Work?	4   Nursing nor		dence 6 Other (S	(pecify)
Division	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place or inj	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (S City or Tox		Rural Route Number,
	ne Hospit 24 hour 18 Funera letely fille	Medical (			of my knowledge, deat if examination and/or in ated.					
	To th withir To th comp	Me	29b. Signature and title of certifier	2- 4-	. 7	29c. License	number 9 C & LL		29d. Date signed (Mo	onth, Day, Year)
•	9		30. Name and address of person who	completed cause of d	death (Item 23a) (Type,	Print)	130T		00/24/	2006
	Sta Regist		2: Zhang MD 31. Date filed (Month; Pay, Year) AUG 3 0 20	32 Registr	Jeath (Item 23a) (Type,	won 15 hol	, Bal	timy e	MD 2	125

McKiver

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Aug 27, 2006 1:10 A M Charles W. Mullins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Anne Arundel <u> Anne Arundel Medical Center</u> 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Yrs. Director MD 228-09-1383 52 May 14, 1954 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes XX No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 USA Funeral 3016 Arundel On The Bay Rd
Marital Status 12. Was Decedent Ever in U.S.
Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: δ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygier Important: if Item 27 is marked other tt any injury or other traumatic event, this once. 12 Attendant Carwash 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ္ Noel Mullins Virginia D. Beverly 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 Light St, Kingsport, TN 37663 Wilma Graham Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Y Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery Aug 30, 2006 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Licen 2. Name and Address of Facility Fink Funeral Home, P.A. N01148 426 Crain Hwy S, Glen Burnie, MD Part1. Enter the disease, shock, or heart failute. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Immediate Cause (Final disease or condition resulting in death) Phenmonia Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter oridenting Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Dementia Altheiners 1 🗌 Yes 3 Probably 4 Unknown Completed Syndrone 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 - Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA 28c. Injury at Work? Certification; 27. Manner of Beath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Hatural 5 Pending within 24 hours after death.

To the Funstal Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOCO58297 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Arnadel Medical Confr. Annapotis MD 21401 MD HOWARD Your 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 3 0 2008 Registrar

			1 - For Stete Registrer		Maryland	Depa Ce	rtificate	t of H	lealth a	and M		g. NO.	06	27387	
2.00	hysici: /Medic		Decedent's Name (First, Midd		Diane M	lurray	,				2. Date of Death Month	Day 1g 23, 20	Year 106	3. Time of Death 10:17a M	
	xamin		4a. Fecility Name (If not institution	on, give street and numb 3209 Northmor			4b. City,	Town, or	r Location o	of Death <b>Baltin</b>	nore	4c. Coun	ty of Death <b>Baltir</b>	nore	
	neral ector		5. Social Security Number 214-64-5423	6. Sex 7. 1 ☐ M 2 🛣 F	Age (In yrs. Ia 51	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Aug 19,			elace (State or Foreign etry) Maryland	
Maryland	incat	tor	Usuel Residence of Decedent  10a. State 10b. County  Maryland	/ N/A	10c. City,	Town or Lo	ocation	В	altimore				1	0d. Inside City Limits	
with the	it be noti	i Director	10e. Street and Number 3209 Northmont Ro	oad			10f. Zip	Code	212	44	10	g. Citizen of	What Cour	,	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	sumstic event, the Medical Examinat must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced	If Yes, Give	es? Ľ <b>X</b> No	1	Was Deced If Yes, spec		lispanic Origin, Mexican	gin? (Spe i, Puerto I	cify Yes or No- Rican, etc.)		ice - Americack, White,		
Maryland 21215-0036  ad 2 should be filed within 72 hours at all and Menhall Hygiens.	he Medical E	Completed	(Specify only higher Elementary/Secondary (0-12)	nt's Education ast grade completed)  College (1-4		(Give	dent's Usua kind of wor DO NOT us	rk done d se retired	during most	t of workii	ng 1	6b. Kind of I		dustry by Schools	
E ag E	tic event.	To Be Co	12 17. Father's Name (First, Middle, Da	Last) aniel Stewart						r's Name	(First, Middle, M	laiden Suma er McClo	,		
e, Mary	r trauma		19a. Informant's Name/Relations Roscoe Murray Hu								Route Number,	-		Code)	
Baltimore, sermit. Pages 1 an Department of Heal	eny injury or other traumatic		20a. Method of Disposition 1 → Burial 2 □ Cremation 4 □ Donation 5 □ Other (5		ate . cer	ice of Dispo metery, crei utus	natory or of	ther plac				Oc. Location	-	wn, State Md . 2122	
Departr	eny injudical		21. Signature Funeral Service	1.8	Sley	SK	2. Name and Es 13	tep B	rothers utaw Pla	Funera ce Ba	al Service, F	P. A. 21217			
ate be executed	the burial-transit	dicai Examiner	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Metas Poue to (or Due to (or c.	as a conseque as a conseque	ence of):	ime.	ev lu	ng.	,		ry arrest, Approximate Interval Between Onset and Death Muchable			
BOX 6	tached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Fetal on nt at time of dea	death 3	]Ectopic pre ] Other (spe		,				ate of delive	ry Day Year	
estha	e de	þ	Part II. Other significant conditi	ions contributing to deal	th but not result	ting in the u	nderlying ca	ause givi	en in Part I.		23e. Did tob			e cause of death?	
T of	page 2	Completed	HTN Huperlitudo	mua							24a. Was an autopsy perform		prior to cor death?	psy findings available inpletion of cause of 2 No	
P P	6 6	n; To Be	25. Wa lase referr d to medical examiner? 1 Yes 2 Voo 27. Manner of Jeath 1 Natur   5 Pendi	Hospital: 1 Inp		R/Outpatier 28b. Time o Injury		A Other	er: 4 🗆 Nu	rsing Hon	(Check only one ne 5 Resider 28d. Describe how	nce 6 Ot		·)	
DIVISION  of or Attanding after death.	in by the fur	27. Namer of Yeath  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury at Work?  1 Natural Accident  3 Suicide  4 Homicide  28b. Dending investigation  6 Could not be determined  28c. Injury at Work?  1 Yes 2 No  28c. Injury at Work?  1 Yes 2 No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred								l Route Number,					
Hospita 4 hours	elly fille	29a. Certifier (Check only one)  29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								use(s) and m te and place	anner as st , and due to	ated. the cause(s)			
To the within 2	ошрі	Me	29b. Signature and title of certific	1/	(.D				e number	7)		d. Date sign			
	12		30. Name and ad ress of person	who completed gause	of death (Item 2	23а) Туре.				317	. Ballin	14011	MD :	21202	
R	Sta egistra	4	31. Date filed (Month, Day, Year, AUG 3 0	2006 2006	gistrar's Signatu	en	24	7		VOL	- IOU		- 432		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8:10 PM M August 25, 2006 **Physician** Elton G. Nelson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Maplewood Park Place Bethesda Montgomery 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/15/1910 Birthplace (State or Foreign OR Country) **Funeral** Months Days 1 M M 2 □ F Hours 543-09-2230 Yrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Itame 23s or 28s-f show the Medical Examiner must be notified at MD Montgomery Bethesda 1 Tyes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814-9707 Old Georgetown Rd. #109 United States filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ð 3. Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Federal Government College (1-4or 5+) 5+ Hygiene. Elementary/Secondary (0-12) Agronomist 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any lipiny or other traumatic avent 2008. 18. Mother's Name (First, Middle, Maiden Sumame) Walter Nelson Mary Chandler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nikki Smith/Daughter 5029 C St. Sacramento, CA 95819-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Aug 29 20c. Location - City or Town, State 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2006 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 1100382 22. Name and Address of Facility Rapp Funeral & Cremation Services Stiple & Holimann 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia 10 days /Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit To the Hospital or Attanding Physician: The law requires thet the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) Records, P.O. been signed by the should be detached 9☐ Unknown 9 Unknown Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes XX No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No s certificate has b lirector, page 2 si Division of Vital : After this certification funeral director. Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 | Impatient 2 | ER/Outpatient 3 | DOA Other: 1 ☐ Yes 🏋 No Warsing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification; To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after dea. 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled in within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0053615 August 28, 2006 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aruna Nathan, M.D.; 11125 Rockville Pike #208, Rockville, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 0 2006 Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Rag. N2006 27389 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Aug. 28, 2006 8:00 P M William W. O'Connor 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Dec. 25 N/A2700 St. Paul Street Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) Maryland 83 1922 218-14-3992 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 2700 St. Paul Street USA 12. Was Decedent Ever in U.S. Amned Forces?
1 (1) Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Valentin Lawrence J. O'Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2700 St. Paul Street Baltimore, MD 21218 Marilyn N. O'Connor - Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Baltimore, MD Aug. 29, 06 Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. P. nt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer of the Bladder 6 Months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypothyroidism 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No Aortic Valve Disease 24a. Was an autopsy performed? Yes 2 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 (Certifying Physician: To the best of pry knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Dey, Year) August 29, 2006 D0015462 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miguel Karacuschansky 200 E. 33rd. Street Baltimore, MD 21218

Registrar

**Physician** 

/Medical

Examiner

Director

Funerai

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Be Completed

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

State

31. Date filed (Month, Day, Year)

AUG 3 0 2006

filled in by the funeral director.

within 24 hours a To the Funeral [

1401

for use as the

**Funeral** 

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. important: if item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event. If a Medical Examinat must be notified at once.

Physician

/Medical

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2006 27390 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** HILVOOT 8:40 MM 5 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A SOULANE BALTIMONE HELLIH & MEALEN TRANKLIM Il Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours 1 M 2 X F Yrs Maryland Director 219-80-4064 Nov 26, 1961 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or Items 23a or 28s-1 show any injury or other traumatic event, the Medical Examinar 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No **Baltimore** N/A by Funeral Director Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1325 Bayard Street 21230 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ☐Yes 2 Yes, Give 2 (XNo 1 ☐ Yes 2 ☐XNo Specify: Specify Black 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Bayview Medical Center** Clerk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Barbara Molock Louis Molock III 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aaron Molock Brother 1325 Bayard Street Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 09/01/06 Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans Cemetery 21. Signatur A Juneral Service Licer 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** cistation /Medical Due to (or as a consequence of) Examiner S—uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, 5 Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown nis certificate has been si I director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 🔀 No 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 ANatural 5 Pending To the Hospital or Attendil within 24 hours after death. To the Funeral Director: Al 1 Tes 2 No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certifier PHYSICIAN 29c. License number 29d. Date signed (Month, Day, Year) SANDHU MB 57543 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 1 940 W 32 Registrar's Signature BALTIMORE ST, SANDHU 31. Date filed (Month, Day, Year) State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month GEORGE VIRGIL PORTER AKA VIRGIL GEORGE PORTER 27, 2006 3:25 p /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8800 Maple Avenue Bowie Prince George's If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1⊠M 2□F 90 Yrs. Director 229-12-2022 3/21/1916 Missouri Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28e-f show 1 Yes 2 □ No Maryland Prince George's Bowie Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Maple Avenue 20720 U.S.A. Funera Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∑Yes 2 No 1943— If Yes, Give Year or Dates: 1946 1 ☐ Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", White 1946 er than "natura". The Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 10 Stocker Woodward and Lothrop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental P John W. Porter Susie Bell Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Ethel C. Porter - Wife 8800 Maple Avenue, Bowie, Maryland 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its eny injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08/31/06 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 01.6346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Prostate Cancer resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of physician and s the burial-transit The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical inding p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 \(\subseteq\text{Yes}\) 2 \(\subseteq\text{No}\) 23d. Date of delivery atter for t 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ sign be ( Completed 1 Tes 2 No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has t irector, page 2 s autopsy performed? 1 Yes 2 No or Attending Physicien: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospitel within 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical å 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ), well you D23743 08/29/2006 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz 7525 Greenway Center Drive, Greenbelt, Maryland 20770 31. Date filed (Month, Day, Year) State AUG 3 0 2006 Registrar

			1 - For State Registrar	State of Maryland / Dep	eartment of Health and ertificate of Death		ene 2006 27392
	Physici /Medi		1. Decedent's Name (First, Middle, Last) ALBERT BALD		R	2. Date of Death Month	Day Year 3. Time of Death 3: 07 A M
,	Examir		4a. Facility Name (If not institution, give s HARBOR HOSPITA		4b. City, Town, or Location of Dea BALTIMORE	th	4c. County of Death
	Funeral Director		411-20-8886	7. Age (In yrs. last birthday  Yrs.	y If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign Country) Tennessee
	e Maryland Ba-f show	Director	Usual Residence of Decedent  10a. State 10b. County  MD Anne Aru	ndel Glen Bur			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28s-f show other treumatic event, the Medical Eventiner must be notified at	by Funeral Dire	10e. Street and Number  403 W. Ordnance R  11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced		10f. Zip Code 21061  Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 □ Yes 2√Ω No Specify:	U	. Citizen of What Country?  . S . A .  14. Race - American Indian, Black, White, etc.  Specify: White
121215-0036	filed within 72 hou Hygiene. other than "natura ent, the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12) 11	cation 16a. Dec (Giv College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)  DMOTIVE Mechanic	rking	b. Kind of Business/Industry  Auto Repair
Maryland	2 should be fi and Mental H is marked of eumatic ever	To Be	Albert Baldwin Pr  19a. Informant's Name/Relationship (Type			me (First, Middle, Mai  M. Andrew  ural Boute Number, C	
Baltimore, Ma	Pages 1 and 2 nent of Health a int: If Item 27 is iry or other tree		Alice Paquette-Pre  20a. Method of Disposition  1	ston, EX-Wife, 105  20b. Place of Disposition State	willow Dr. Hatfie osition (Name of unatory or other place)	ld. PA 194 Date 200	
Baltii	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service License	atio	2. Name and Address of Facility 5305 Harford Rd.	Leonard J. Baltimore,	Ruck, Inc. MD 21214
	Physician /Medical Examiner		23a. Pan1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	NECE PREUMOR		Approximate Interval Between Onset and Death
8/60,	cate be executed obysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underthyling Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):			
O. Box 68	ath certifi ttending j or use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
<u>,</u>	quires that the de n signed by the a uld be detached i	d by Pr	Part II. Other significant conditions conf END STAGE	ributing to death but not resulting in the CRENAL DISEASE	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
II Kecords	The law ete has b page 2 si	Completed	AWIE M	YOCARDIAL INFAR	ction	24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
or vital	Physician: Th this certificete ral director, pag	To Be	25. Was case referred to medical examiner? 1  Yes 2 No	ospital: 1 Inpatient 2 ☐ ER/Outpatie	T 044	ath <i>Check only one)</i>	e 6 ⊡Other (Specify)
	Attending Phir death.  ector: After the by the funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurred
Š	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At home, farm, st building, etc. (Specify)		City or Town, S	
	the Hosp in 24 ho the Fune pletely fi	Medical	29a. Certifier 1 ☐ Certifying Physi (Check only one)	cian: To the best of my knowledge, dea er: On the basis of examination and/or in and manner stated.)	th occurred at the time, date and place evestigation, in my opinion, death occu	e, and due to the cause arred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
)	To with To I	2		NEDICAL KESIDEN			Date signed (Month, Day, Year) UST 29 2006
	13		30. Name and address of person who con MA, BELINDA LL	npleted cause of death (Item 23a) (Type D, MO 3001 C. HAN	Print) OVERST BALTIM	ORE, MO	21225
F	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature			

DHMH 17 Rev 1/2001

			1 - For State Registrar		f Marylan		artment tificate				lental Hyg	jiene <sub>leg. No</sub> 2 (	006	27393
	Physici /Medi		1. Decedent's Name (First, Middle, Gerard H. Pilachows	ki							2. Date of Dea Month August 2		Year	3. Time of Death 3:15 Р м
	Examir	ier	4a. Facility Name (If not institution, 3701 Bayonne Avenue				-	imore	Location of			N/A	nty of Death	
	Funeral Director		5. Social Security Number 219-01-9214  Usual Residence of Decedent	6. Sex 1 M 2 □ F	7. Age (In yrs. 87	Yrs.	Months	Days	Hours	Min.	Apr 11 26	1919	9. Birthp	lace (State or Foreign and
	Maryland	tor	10a. State 10b. County  Maryland N/	'A		y, Town or Lo Baltimor				·			1	0d. Inside City Limits 1   Yes 2   No
	with the	Funeral Director	10e. Street and Number 3701 Bayonne Avenue				10f. Zip	Code 1206				0g. Citizen o		try?
5-0036	ours after deat rel', or items ? Examiner mu	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed Fo	2 No WWI	I.		ent of His	spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	14. R.	ace - Americ lack, White, hity: White	etc.
21215-0	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "naturel", or items 23s or 28e-f show imaric event, the Madical Evaninar mark to rolling at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12		-4or 5+)	16a. Deced (Give life. L Machin	kind of worl DO NOT use	k done di	urina most	t of worki	ng	16b. Kind of Beth1	Business/Ind	•
Maryland 2121	ed fa b	To Be (	17. Father's Name (First, Middle, L Leo Pilachow						18. Mothe		(First, Middle,	Maiden Suma	ame)	
	trat		19a. Informant's Name/Relationshi Catherine M. Cushatt								Route Number			
Baltimore,	Pages 1 ar nent of Hea int: If Item? iry or other		20a. Method of Disposition  1  Burial 2  Cremation 3 4  Donation 5  Other (Spe	B Removal from Secify) Entomore	State	lace of Disposemetery, cren rdens of	sition (Name natory or oth Faith	e of her place			30,2006	20c. Location Baltimo		
Balt	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Li	censee Affecte	-	122 120 53	Name and opard of Har	Address J. Ru Ford	s of Facility	v	more Mary			
	Proysician		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition	omplications that can be one cause on each	aused the death ach line.	1	or the mode	1	, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
6	Medical Examiner who by sician and the purial-transit	Examiner	Sequentially list conditions, if any, leading to minimulate cause. Einer Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Cor Dun to (	or as a consequence or a consequence or a consequ	uence of):	ter,	rev	d ten:	1se siw	ase 1	-		8 pens Ce yens
O. Box 68760	ath certific	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nth 2 ☐ Fetal ant at time of de	death 3 🗌	Ectopic pre- Other (spe						eate of deliver	ry Day Year
rds, P.	quires that the de n signed by the a ald be detached f	þ	Part II. Other significant condition	s contributing to de		ulting in the un	derlying car	use giver	n in Part I.			pacceruse cor		e cause of death?
Vital Records,	The ate h pege	Completed									24a. Was a autops perform	v	. Were autop prior to con death? 1 \(\sum \) Yes	asy findings available apletion of cause of
T VITA	ysiclan: is certific director,	To Be (	25. Was case reterred to medical examiner?  1 □ Yes 25 No	Hospital: 1 ☐ Ir	npatient 2 🗆 l	ER/Outpatient	3 🗆 DQA	Othor	~		(Check only on	مراه		
sion of	To the Hospital or Attending Physician: whith 24 hours after deals. To the Funeral Director: After this certifical completely filled in by the funeral director; it		27. Manner of Death  1 Natural 5 Pending 2 Accident investiga	tion	f Injury b, Day Year)	28b. Time of Injury	28 M	c. Injury Work? 1 🗆 Y		2	8d. Describe ho			
DIVISION	ital or Att rs after de al Directi led in by t	Certification:	3 Suicide 6 Could no determin	ad 286. Place	of Injury - At ho g, etc. (Specify	me, farm, stre	et, factory,	office		2	8f. Location (St City or Town	reet and Num , State)	ber or Rural	Route Number,
	the Hosp in 24 hou the Funer spletely fil	ledicai	29a. Certifier 1 Certifying (Check only one)	Physician: To the saminer: On the ba and mann	sis of examinat	ion and/or inv	estigation, i	n my opi	nion, death	h occurre	ed at the time, da	use(s) and mate and place	anner as sta , and due to	ited. the cause(s)
	To con	Σ	29b. Signature and title of equifier	2_	of death (Item		29c.	License	number 5	8-90	25 /	Date sign		2006
	10+1		30. Name and audies of person w	no completed cause	of death (Item	23a) (Type, F	Print)	1)~	N	ren	104-/	Hus	1:401	1
	Sta Registr	_	31. Date filed (Month, Day, Year) AUG 3 0	2006 32. Re	gistrar's Signat	ture	edi;						/	

State of Maryland / Department of Health and Mental Hygiene 2006 27394 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Delisa Rich Month Κ. 08 q 10:20 AM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Franklin Square Hospital
5. Social Security Number 6. Sex 7. A Center Roseda Baltimore 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🖫 F Hours Yrs. Director 213-84-2807 39 7-25-1967 Md. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at Funeral Director 1 ¥ Yes 2 □ No Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3101 Longview Avenue 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Counselor Woodbourne Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental Thomas Matthew Rich Viola Eleanor Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Viola Anderson Mother 3101 Longview Avenue, Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of It
Important: If Ite
any injury or of MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-31-06 Dundalk, Md. Trinity Cem. 21. Signature Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Avenue, Baltimore, Md. 19 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician AIDS 2 yrs /Medical Due to (or as a consequence of): Examiner infection Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). anding physicien and Ruse as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. | ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 2 X No 1 🗌 Yes 3 Probably 4 Unknown should should Completed Kapsosi's Sacroma 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No page 2 Hepatitis CInfection certificete Division of Vital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) or Alter.
, efter death.
al Director: After this of the funeral director of the funeral director. 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manger of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours effer To the Funeral Dire 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number BN850506 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive, Baltimore MD 21237
36 Registrar's Signature Dr. Anita Naik MD
31. Date filed (Mogth, Day Year)
AUG 3 0 2006 State Registrar

Rich, Delisa

State of Maryland / Department of Health and Mental Hygiene 27395 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mont 08 Day 28 2006 10:20 a<sub>M</sub> Genevieve D. Rock /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Baltimore Towson Dulaney 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1/20/1920 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 219-10-5743 Maryland Director 86 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County Ahow 10d. Inside City Limits r 28e-f ahow Baltimore Edgemere 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or itema 23a or: ury or other traumatic event, the Medical Examinational ber 21219 U.S.A. 2825 Lodge Farm Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White þ 1 Yes 2X No Specify: 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8 Own Home n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank DeLuca Dolly Ditorie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health ar important: If item 27 Is any injury or other trau <u>Theresa, Mueller, Daughter</u> 10 Watergreen Lane, Berlin, MD 21811 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 08/31/2006 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. Ulsandua 5305 Harford Rd., Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Yeri Phenal **Physician** lascular /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death signed by the e 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ cete has been signated bage 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No this certificate has autopsy performed 1 Yes 2 No Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 SoNo ၉ 27. Manner of Death After t 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? al or Attending P i after death. i Director; After t d in by the funera Certification: 28d. Describe how injury occurred 1 Natural 5 Pending Injun 1 □Yes 2 □No 2 Accident investigation М 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0054424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 3 0 2006

32. Registrar's Signature

Cyrus Adadi, MD 20 East Timonium Rd. Kelly Bldg. Ste. 209 Timonium, MD 21093

State of Maryland / Department of Health and Mental Hygiene 2006 27396 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Gladys Augusta Roesler August 27 2006 4:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore tf Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 22 1920 **Funeral**  Birthplace (State or Foreign Country) Months 1□M 2□F X Director Yrs 215 12 0592 Baltimore, Maryland Usuat Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Madical Examiner must be notified at Director Maryland Baltimore 1 ☐ Yes 2 ☐ No Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 7615 Belair Road 21236 or Itsms 23a USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Stack, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify. 3 Widowed 4 Divorced "natural", White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) N/A Line Foreman Bendix 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William F Marx ျှ Mary A Meskill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 Linda M Miller (Neice) 16 Brightoak Court Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Depertment of H Important: If Ite any Injury or ot 2002. 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cem. August 30 2006 Baltimore, Maryland 21. Standard of Funeral S vice Licensee 22. Name and Address of Facility
Lassahn Funeral Home Inc. 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each ting. Approximate tnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UMICEd an /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has tirector, page 2 s 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? To Be 26. Place of Death | Check only one Hospitat: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi funeral of 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Medical Certification: 27. Manner of Death 28d. Describe how injury occurred 1 -Natural 5 Pending investigation s after decay Director: Alb 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a
To the Funeral C o the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and till of confifier 29c. License number , uno Beath (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 3 0 2006 Registrar

			1 - For State Registrar	State of Maryland	/ Depa	artment of H	lealth and Death	Mental Hygie	ene 2006	27397
	Physici /Medi		Decedent's Name (First, Middle, Last)     Mary Dougle	as Ross				2. Date of Death Month August 2	Day Year	3. Time of Death 8:20 P
	Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Dea		4c. County of Deat	
			203 Worthmont Ros				nsville		Baltimo	
ı	Funeral Director		217-03-6011	7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. Birt 1918 Mar	thplace (State or Foreign ountry) yland
	land w		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mary I-f eh	ţō	MD Baltimon	re	Baltir	nore				1 ☐ Yes 2 No
	or 284	lrec	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?
	ath w	rai	6711 Edward Ave			2124			USA	
980	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or items 23s or 28s-1 show aumatic event, Its Midical Examinat must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Vidowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2∰No If Yes, Give Year or Dates:	1	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify:	
2-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced	ent's Usual Occupa	ation	rking 16	b. Kind of Business/	Industry
121	within	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of NOT use retired emaker	)		den Homo	
0	filed Hygie		11 17. Father's Name (First, Middle, Last)		TIOME	Maker	18. Mother's Na	me (First, Middle, Ma.	Own Home	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be l Depertment of Health and Mental Important: If item 27 ie marked o eny injury or other traumatic eve <u>once</u> .	To Be	John Christopher				Edith	R. Muse		
Mai	d 2 sh th and 7 ie m traum		19a. Informant's Name/Relationship (Type Doug Jones	Grandson				ural Route Number, C		
ē,	s 1 an i Heal item 2 other		20a. Method of Disposition		e of Dispos	sition (Name of natory or other place	t Road;	Catonsvill	Le, MD 212 Location - City or	
Ē	Pages ent of nt: if i		1   Burial 2 □ Cremation 3 □ Re  Donation 5 □ Other (Specify)	DINOVAL HOIR STATE		Mem. Par	)			Maryland
alti	pertm porta y inju		21. Signature Ineral Service License		22.	Name and Address	s of Facility St	erling-Ash	rton-Schwa	ab-Witzke
m —	88558		/ May	tall	16	30 Edmon	me of Ca dson Ave	erling-Asi tonsville, nue; Cator	, Inc. Isville, M	ID 21228
	Physician /Medical Examiner		262 Fart 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. e cause on each line.  Due to (or as a consequer	Co	in the mode of dying	g, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
	death certificate be executed e attending physicien and of for use as the burial-transit	icai Examiner	Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer						
ž ×	ertifica ding pt se as t	/Med	IF FEMALE:	N. W					T	
O. Box	i that tha death certific ted by the attending p detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	ath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
rds, P	law requires that tha as been signed by the 2 should be detached	þ	Part II. Other significant conditions conf	tributing to death but not resultin	ng in the un	derlying cause give	n in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Y	The ate h page	Completed						24a. Was an autopsy performed 1 Yes 2	prior to o death?	topsy findings available ompletion of cause of
<b>=</b>		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER	10.4	Othe	<u>_</u>	ath (Check only one)	**	grand-
Ĕ	or After	$\vdash$	27. Manner of D th  1		Outpatient  B. Time of Injury	28c. Injury Work	4   Nursing H	lome 5 Residence 28d. Describe how i		mson's residen
DIVISION	Hospital or Attends 24 hours after death. Funerel Director: A stely filled in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	t and Number or Rui tate)	ral Route Number,
	To the Hospital or A within 24 hours after To the Funerel Directompletely filled in by	dical	29a. Certifier (Check only one) (Check only one)	ician: To the best of my knowle er: On the basis of examination and manner stated.	dge, death and/or inve	occurred at the time estigation, in my op	e, date and place inion, death occu	, and due to the cause rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	¥ €	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month	, Dey, Year)
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5	- 1		- 11. 13.11	mpleted cause of death (Item 23			Do Ido			7
ř	Sta	e	Edd Ye Bullock 31. Date filed (Month, Day, Year)	141 Secur 32 Registrar's Signature	KITY	DIVO.	DU ITUM	iore MI	J व्यावि	+4
	Registr		AUG 3 0 2006	Marie De	JUG0	West .				

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedeni's Name (First, Middle, Last) 2. Date of Death Physician Month Year Hugust Rosemary Smith 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Upper Chesapeake Hospital Bel Air Harford If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 200 F 48 215-74-9408 Yrs. Director MD 11/16/1957 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r 28a-f ahow anctified at 10d. Inside City Limits 1 ☐ Yes 2 No Harford Edgewood Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Fxantiner must be a 21040 2009 Bayberry Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White δ 3 Widowed 4 Ni Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Free Lance filed within other than Elementary/Secondary (0-12) College (1-4or 5+) Artist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) l end 2 should be f lealth and Mental I Rosemary Is marked Edgar Smith Kay Sugiyama 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jan Hasselbusch/Sister 1320 Winding Valley Drive Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State Aug 28 1 ☐ Burial 2 2 Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory Inc. 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives J8900H 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** MOXIC /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its tool are only in the cause of the cause o Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death in the past 1 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f N 800343839 Division of Vital Records, P.O. I 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 X No certificate 1 ☐ Yes 2 No : After this certifical funeral director, [ 25. Was case referred to medical Be 26. Place of Death | Check only one 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Certification: To 2 ER/Oulpatient 3 DOA 28a. Date of Injury (Month, Day Year) of Cath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 KNatural 2 ☐ Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funerel Direct completely filled in by filled in by 4 Homicide ō Cartifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D40819 August 26,2006 ance aucre 30. Name and address of person solution letted cause of death (Item 23a) (Type, Print) pper Chosapeake Dr. Beltir, MO 21014 Marco Zamor mD=500 U a 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006 27399 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Mary Sullivan Α. 22. 2006 August 2:25A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 8. Date of Birth (Month, Day, Year) Nov. 22,1927 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🛛 F Months Director 78 Yrs. 481-24-7317 Iowa Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location ir than "natural", or iteme 23a or 28e-f ehow the Medical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MD Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 938 Olmstead Road Funeral USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: ۵ 3 ☐ Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress Stewarts t of Health and Mental Hygie if Item 27 is marked other or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John A. Moore Grace K. Weber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Leeman Son 1021 Kingston Road, Pikesville, MD 21208 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ŏ Depertment of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 8/25/06 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road Sle Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that vaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartifailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ADENOCARCINOMA UNG with Metastases **Physician** Morths disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo
9 Unknown Month Day Year signed by the a 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 s 24a. Was an autopsy performed? Yes 25 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSP CE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending s efter dea. 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2/ Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospitel of within 24 hours of To the Funerel D Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Faulleres MD 6601 W. Charles (Neet 31. Date filed (Month, Day, Yeer) 32. Angistrar's Signature State AUG 3 0 2006 Registrar

06-06456 Mary Scott

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 27400

			1- For State Registrar		Certific	ate of	Death			Re	g. No.	200	70	2/40
Ph	ysicia	ın/	1. Decedent's Name (First, Midd							Date of Death Month	1	Vasa	3 Time o	Death
Medical E	xami	ner	Mary Kathlyne N						Á	Nugust 28,	2006	Year	1435	hrs
			4a. Facility Name (if not institution			4	b. City, Town, o	r Location o	of Death			ounty of Dea		
			8432 Charles Valley (				Towson					timore Co		
	neral		5. Social Security Number	6. Sex 7. Ag	e (In yrs last bir	thday)	If Under 1 Yes			. Date of Birtl	n(MM/DD	/YYYY) 9. B Fore		ate or
Dire	ector		218-68 <b>-</b> 8770	1 M 2XF	50	Yrs.	Months	ys Hours	,   ,,,,,,	Novembe	er 1,	1955 🙃	ountry)Ma	cyland
			Usual Residence of Decedent										· · · · · ·	
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and	28a-f show d at once,	ō	Maryland Balti	more	Tows	on							1Ye	s 2 X No
Mary	28a-	Director	10e Street and Number	11 0			10f. Zip Code			10	-	of What Co	•	
the	3a or		8432 Charles va	illey Ct., Ap	t. A		21204	+			Unit	ed Sta	ates	
hours after death with the Maryland	or items 23a or 28a-f sho must be notified at once,	Funeral	11. Marital Status	12. Was Decedent Armed Forces?			Decedent of Hi				14.	Race - Ame White, etc.	rican Indian,	Black,
deat	or ite	ᆵ		1 Yes 2	X No				, r derio rica	an, etc.)				
after	ral",	à		orced If Yes, Give Year or Dates:			Yes 2X No					ecify: wh		
hours	other than "natural", the Medical Examiner	b	15. Decedent's Education (Spe				s Usual Occupa st of working life				16b. Kind	of Business	/Industry	
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within	Med	틩	17. Father's Name (First, Middle		1	cal c	scale a		'a Nama /Fis	st, Middle, M			state	
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21215-0036 uld be filed within 7 Mental Hygiene	marked c event,		19a. Informant's Name/Relations		19	b. Mailing	Address (Stre						a Zin Code)	_
re, MD 21. I and 2 should B Health and Mer	tant: If item 27 is marked or other traumatic event,		Kevin Thomas Sc		10.0		/alleyfi							
and and Health	item r trau	ŀ	20a Method of Disposition		20b. Place	of Disposit	ion (Name of ce			ate		ation - City o		
Baltimore, permit Pages Lar Department of He	other ::		1 Burial 2 X Cremation		110	ory or oth		ļ						
ti Pa	y or	-	4 Donation 5 Other S 21. Signature of Funeral Service		Green	ount	cremat	ory	<u>Aug. 3</u>	<u>0,200€</u>	<u>Ba</u>	<u>ltimor</u>	e, Ma	ryland
Baltimore permit. Pages 1 Department of F	Impor injury		Ophi A M	to line		22. No	Mitché 6500 Y	TITE WY	ledefe	ld Fun	eral	Home,	Inc.	
Physic			23a Part I. Enter the disease, or	complications that caused	the death. Do no	ot enter the	e mode of dving	LOLK I	ardiac or res	DATUIII	ore,	or heart		nate Interval
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8760, tificate b	50 (0		23b. Was decedent pregnant in t			Feta	al death 3	Ectopic	pregnancy			ate of deliver nth	y Day	Year
Box 68	for use as	ici Cia	past 12 months?		time of death		er (Specify)				1			
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/ita /sicia	this certificate I director, page	e Be	examiner?	Hospital: 1 Inpatie	nt 2 ER/O	utpatient		Other <sub>4</sub>	Nursing Ho		tesidence	6 🗸 Othe	r: Scene	
Division of Vital Records, P.O. Box 6: ral or Attending Physician: The law requires that the death cert rs after death.	After the	$\vdash$	27. Manner of Death	28a. Date of Inju (Month, Day,Y	ry 28b.	Time of In	jury 28c. Inju	ury at Work	<u> </u>	I. Describe ho				$\overline{}$
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'iSic Affice er des	S 5	ig	. []	stigation 28e. Place of Inj	ury - At home, fa	arm, street	, factory, office	building, etc	c. 28f.	Location (St	reet and N	Number or Ri	ural Route N	umber, City
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20	1		30. Name and address of person	who completed cause of d	eath (Item 23a)									
) 50 p	2nd		·	sistant Medical Exan		Penn S	treet, Baltim	ore, MD	21201					
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			1 - For Stete Registrer	State o	f Maryla	nd / Depa	artmen rtificat			ind M	-	giene Reg. No.	20	06	271	40
	Physici		Decedent's Name (First, Middle Gloria		Anne		Sw	_ ansor	n		2. Date of De Month 8	Day 24	200	ar	Time of De	eath M
	/Medic Examir		4a. Facility Name (If not institution Gilchrist Hos	, give street and nu			1		Location of	f Death	<u> </u>	4c.	County of D Balti	eath		
	Funeral Director		5. Social Security Number 217–58–6464	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs	. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bird (Month, Da 1-16	h y, <sub>Year)</sub> 5–195	0 9.1	Birthplace Country)	(State or Fe	oreign
	Ba-f show	Director	Usual Residence of Decedent  10a. State  10b. County  Md.	NA	10c. C	ity, Town or Lo	timor							1	Inside City L	
	h with th		10e. Street and Number 1649 N. Milton	Avenue			10f. Zip	Code 2121	3			10g. Citiz	en of What USA	Country?		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Itam 27 is marked other then "natural", or Itame 23a or 23a-f show any Injury or other traumatic event. I've Medical Examinar motal to notified at once.	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	2 <b>X</b> No		Was Deced If Yes, spec	_	spanic Orig n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No Rican, etc.)		4. Race - A Black, W Specify:			
21215-0036	within 72 ho ane. then "natur	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade completed) College (		life.	kind of wo DO NOT us	rk done di se retired)	uring most		ig .		d of Busine			Dan
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Maryland	hould b d Menta narked natic e	T <sub>o</sub>	Ernest		c.	Swan		(0)	Mar					son		
ore, Ma	ges 1 and 2 s t of Health an If Itam 27 Is or or other traur		19a. Informant's Name/Relationsh  Gregory L. Swan  20a. Method of Disposition  T√ Burial 2 □ Cremation	son Br	State	1131 Place of Dispo cemetery, crer	Colusition (Name	mbia ne of ther place	Rd.	N.W.	, Washi	ingto		c. 2	20009	
Baltimore,	permit. Pa Departmen Important: any Injury once.		4 Donation 5 □ Other (Science L	pecify)	D <sub>2</sub>	100	. Name an	d Address	s of Facility		06 March H , Balti	F.H.	East Md.	212	202	
	The law requires that the death certificate be executed:  The law requires that the death certificate be executed:  The law requires that the death certificate and the law representation and the law representat	dicai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock of the	a	ach line.	quence of):					төэрнатогу аг	rest,		Inte	proximate mval Betwee set and Dea	
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ð	To the Hospital or Attending Physician: The la within 24 burus after death, within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Naturat 5 Pending 2 Accident investig	28a. Date (Mon		ER/Outpatien 28b. Time of Injury		A Other 8c. Injury Work	4 🗆 Nur	sing Hom	(Check only only only only only only only only	ence 6		pecify)	Hosp	ice
Divis	tal or Atters after detail Directo	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 288. Place	of Injury - At h	iome, farm, stre	eet, factory	, office		21	8f. Location (S City or Tow	itreet and n, State)	Number or	Rural Rou	ite Number,	
	To the Hospital or within 24 hours afte for the Funeral Dir. completely filled in I	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the examiner: On the base and man	best of my knoasis of examination stated.	owledge, death ation and/or inv	occurred restigation,	at the time in my opi	e, date and nion, death	place, ar occurre	nd due to the o	ause(s) a date and p	nd manner place, and d	as stated. ue to the	cause(s)	
)	To the within To the comple	≥ 1	29b. Signature and title of codifier	Thung K	ily	, ans	290	. License	number	5		Aug	signed (Mo	onth, Day,	Year) 2006	5
	641		30. Name and address of person v  A - R  31. Date filed (Month, Day, Year)	who completed caus	e of death (Ite	m 23a) (Type,	Print)	f-Ci	hark	les S	1. B	alt.	- nd	2	( ZU,	بر
	Sta Registr		31. Date filed (Month, Day, Year)	2006 32.4	èdistrar's Sign	aldres 19										

			1 - For State Registrar		laryland / D	epartme	ent of Health and ate of Death	Mental Hygie	_	5 27402
			1. Decedent's Name (First, Middle, L		dina		_	2. Date of Death		3. Time of Death
	Physic /Medi		Eugene 1	Milliam	Snyde	, 5		August a	Day Year 2000	(2:45 M
	Exami		4a. Facility Name (If not institution, g		)	4b. C	ity, Town, or Location of De		4c. County of Deat	
X			Canoll Hos	bital Ca	Suter		Mestmi	nstar	(31/	1/6
DE	Funeral	25.0	Social Security Number     6.	Sex 7. Ac 1 2 M 2 ☐ F	ge (In yrs. last birtl	Month	der 1 Year If Under 24 Hi		year) 9. Birt	hplace (State or Foreign buntry)
>	Director		210-20-1397	123 M 2 F	74	rs.		MAR 17,	1932 Mar	yland
SNYDER	and **		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
2	Maryl 1 sho	ō	Maryland Carro	17			E7 danahaan			1 ☐ Yes 2 <b>X</b> No
	with the Maryland a or 28a-f show be notified at	Director	10e. Street and Number			10f.	Eldersburg Zip Code	100	g. Citizen of What Co	ountry?
V	5-0036 2 hours after death with the Marylar atural', or Items 23a or 28a-f show tail Examinat the mailfied at		6212 Longmead	low Drive			21784		USA	,
7	death ums 23a	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was De	cedent of Hispanic Origin? pecify Cuban, Mexican, Pue	(Specify Yes or No-	14. Race - Ame	
4	6 after		1 Never Married 2 Married	Armed Forces				erto Rican, etc.)	Black, White	
-	5-003 72 hours in inatural; of other learning in the other learnin	d by	3 Widowed 4 Divorced	Year or Dates:		1 🖵 1 🖰	3 2. XNo Specify:		Specify: W	hite
7	15-0036 72 hours after death w naturel; or Items 23e	ete	15. Decedent's I (Specify only highest g		16a.	Decedent's U (Give kind of	sual Occupation work done during most of w Tuse retired)	rorking 16	6b. Kind of Business/	Industry
7/	and 21215-0036 be tited within 72 hours atter ital Hygiene. ed other than "natural", or Ital	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		r use retired) Mechanic		011 0	
2	d 21 filed will Hygien other th		17. Father's Name (First, Middle, Las	(t)		reser		ame (First, Middle, Ma	Oil Compar	ny
2	Z Sa a S	To Be	John Carl Snyde	er. Sr.				ude Gosnel		
V	Maryland 212. Id 2 should be filed within the and Mental Hygiene. Z7 is marked other than traumatic event, Iram	-	19a. Informant's Name/Relationship	,	19b.	Mailing Addr	ess (Street and Number or I			Zip Code)
m	22 mg ≤ 2 mg ≤		Anna M. Snyder/V	life.			ngmeadow Dri			
3	Baltimore, Moermit. Pages 1 and 2 Department of Health mportant: if item 27 in injury or other transcent.		20a. Method of Disposition		20b. Place of				Oc. Location - City or	
6.2	Baltimor permit. Pages Department of I Important; if its any injury or of		t ☐ Burial 2 XCremation 3 4 ☐ Donation 5 ☐ Other (Spec		*		ory, Inc. 8/	31/06	Baltimore	e MD
3	altim mit. Pag partment; portant; y injury		21. Signature of Funeral Service Close	ensee		22. Name	and Address of Facility M	acNabb Fun	eral Home	. P.A.
17	<b>m</b> && <b>E a</b>	100	Edward A. Gr	egorchik		301	Frederick Ro	ad Catons	ville, MD	21228
	- <del>*</del>		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cause y one cause on each I	d the death. Do no	ot enter the m	node of dying, such as cardi	ac or respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	2		PRV	ipnitis			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence o	f):				
	LAGITHTE	_	Sequentially list conditions,	b						
. 0	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence o	t):				
Sal	760, U	хап	that initiated events resulting in death) Last	cDue to (or as	a consequence of	f);				-
•	760, te be ex ysiclan	calE		814						
		edlo		d						
	Box 68'	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of deli	ivery
	death death ad for	lcla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a	2 Fetal death It time of death	3 □Ectopia 5 □ Other			Month	Day Year
	P.O. Inat the ded by the a	Physician/M	9 🗆 Unknown	9□ Unknown					1:	
	S, F es tha igned I	by	Part II. Other significant conditions	- 1.		the underlyin	g cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
	of Vital Records, Physician: The law requires t this certificate has been signe ral director, page 2 should be c		YZev	121 -211	ne			1 ☐ Yes	2. No 3 □ Pro	obably 4 Unknown
	law relay be	Completed	Congesti	re Hear	7-3110	R		24a. Was an autopsy	24b. Were au	topsy findings available
	The The page	50	) `	,	,			performe	death?	2 No
	Vital F ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					eath Check only one		
	Of Physical this control of the cont	ြို	1 ☐ Yes 2 ☐ No	Hospital: Inpatie				Home 5 Residence		cify)
	ding F h. After funer	lon:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Da	ury 28b. Ti ay Yea <i>r)</i> In	jury	28c. Injury at Work?	28d. Describe how	injury occurred	
	Division  for Attending after death. Director: After	Certification:	2 Accident Investigation 3 Suicide 6 Could not	De Olean ette	jury - At home, fari	M street fact	1 Yes 2 No	28f Location /Stree	et and Number or Ru	m I Pauto Number
	Div A after Direct Dire	ertil	4 Homicide determined	building, ei	tc. (Specify)	ii, street, raci	ory, onice	City or Town,	State)	rai Houle Number,
	spita lours neral		29a. Certifier Certifying P	hysician: To the best	of my knowledge.	death occurr	ed at the time, date and place	ce, and due to the cau	se(s) and manner as	stated
	Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edical	one) Z Medical Exa	miner: On the basis of and manner st	of examination and	or investigati	on, in my opinion, death occ	curred at the time, date	and place, and due	to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	- 14. C.	20 -		29c. License number	29d	d. Date signed (Month	n, Day, Year)
				DVIC MA	KIMA		10003994	3 A	rypust 2	812000.
_	Q		30. Name and address of con who	completed cause of o	death (Item 23a) (T	ype, Print)	- \ \			74.
	0		John C. Anel M	0 295	2 bush	Me.	SUR 307	nosmin:	STEV ME	> 21157
	Sta Registr		31. Date filed (Month, Day, Year) AUG 3	2006 32. Registr	rar's Signature	Spark	San 3			

			1 - For State Registrar	State of Marylar		artmen			and Me		giene 2	006	27403
	Physici /Medi		1. Decedent's Name (First, Middle, Last)  JEFFERY A	TRIPP						2. Date of Dea Month		2006	3. Time of Death 5:05 PM
	Examir		4a. Facility Name (If not institution, give:  WN IVERSITY OF MA  5. Social Security Number 6. Security Numbe			M	BAL	T7M0	REC	8. Date of Birt	h	9. Birth	place (State or Foreign
	Director		528-56-6383 142  Usual Residence of Decedent  10a. State 10b. County	64	Yrs. ty, Town or Lo		Days	Hours	MIII.	AŬG 4,	1942	U	tah  10d. Inside City Limits
	th the Mary or 28a-f eh	Director	Maryland Anne Aru	nde1		10f. Zip		rna I	Park		10g. Citizen	of What Cou	1 ☐ Yes 2 ☑ No
36	ges 1 end 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Itam 27 is marked other then "naturel", or Iteme 23e or 28e-f ehow or other treumatic event, the Mexical Examinar must be notilised at	by Funeral Director	221 McKeon Road  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1  ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Deced If Yes, spec	dent of His cify Cubar		gin? (Spec i, Puerto R	ify Yes or No- lican, etc.)	14. F E Spe	USA Race - Amerillack, White,	etc.
Maryland 21215-0036	d within 72 hou giene. er then "nature ir e Medicel E	Completed I	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give	dent's Usua kind of wor DO NOT us	rk done d se retired)	uring most	of workin	g			nt of
aryland	4.2 should be fitted within h and Mental Hygiene. 7 is marked other then "treumatic event, the Me.	To Be C	17. Father's Name (First, Middle, Last)  Alma Allen To 19a. Informant's Name/Relationship (Ty)	- 1-1-					Hele	(First, Middle, en Iren Boute Numbe	Maiden Sum le McLa	ame) nughli	n
Baltimore, Ma	permit. Pages 1 end 2 Depertment of Health a Important: If Itam 27 is eny injury or other tree 2005.		Patricia A. Trip	20b. Femoval from State	221 Place of Disposemetery, creation Cre	matory or o	ne of ther place	) 1	Da		20c. Locatio	n - City or T	
Baltir	permit. Pages. Depertment of H Important: If Its eny injury or of		21. Signature of uneral Service License	egorchik	2:	2. Name an 299 F:	d Address	s of Facility	Cren Road	nationS Balti	more,	of M	D, Inc.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat ine cause on each line.  Levebro  Due to (or as a conseq  Hypert	uence of):	Dow				respiratory ari	rest,		Approximate Interval Between Onset and Death
68760, 🕹	rate be executed obtaining and the burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to r s a conseq									
P.O. Box 68	ne death certific the ettending p thed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	death 3	□Ectopic pro □ Other (sp						Date of deliver	ery Day Year
	equires that the second of the second by the detaction of the detaction of the second	þ	Part II. Dther significant conditions con	tributing to death but not res	ulting in the u	nderlying ca	ause givei	n in Part I.		23e. Did to	30		he cause of death?
of Vital Records,		Completed							_	24a. Was a autop: perfor	sy	prior to co death? 1 Yes	opsy findings available impletion of cause of
<b>Vit</b>	sicia cer rect	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 Inpatient 2 🗆	ER/Outpatier	- a - Do	Other			Check only or		Nt. (0	
	g fee	ation: To	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury Work	4 🗀 Nui	28	e 5 Resid			y)
Division	= 9 = -	i Certification:	3 Suicide 6 Could not be determined	28e. Ptace of Injury - At he building, etc. (Specif	y)					City or Tow	n, State)		al Route Number,
	To the Hospital of within 24 hours of To the Funerel D completely filled in	edical	29a. Certifier (Check only one)  1 ★ Certifying Phys 2 ★ Medical Exemin	sician: To the best of my kno ner: On the basis of examina and manner stated.	tion and/or in	n occurred a vestigation,	in my opi	e, date and nion, deat	place, and hoccurred	d at the time, d	ause(s) and late and place	manner as s e, and due to	tated. the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	1 2			License			2	29d. Date sign		
			Marsh ym	beliannis			1417 -				08/	15/0	1006
	\2 Sta	to.	30. Name and address of person who co KIARASH ZAK 31. Date filed (Month, Day, Year)	mpleted cause of death (Item  BALIAN  32. Registrar's Signa	123a) (Type, 225. (- lture	Print)	NE	ST.	BAL	TIMO	RE,	MD	20201
	Registr			32. Registrar's Signa	N. 1	Goods	-						

		1 - For State Registrar	State of Marylan		ent of Health and ate of Death	R	eg. No 2006	
Physicia /Medic		Decedent's Name (First, Middle, Last)	Marjorie :	K. Tolson		2. Date of Deat Month August	Day Year 27, 2006	3. Time of Death 12:16 P <sup>M</sup>
Examin	er	4a. Facility Name (If not institution, give s  Laurel Regional H  5. Social Security Number 6. Sex	ospital	La	ity, Town, or Location of De ure1 Ider 1 Year   If Under 24 H		4c. County of Dea	
Funeral Director		Usual Residence of Decedent	M 2 🖾 F 88	Yrs.	hs Days Hours Mi	June 21	, 1918 Mai	cyland
ne Marylan Ba-f show	Director	MD Prince G						10d. Inside City Limit:
ath with the 23a or 2	eral Dire	10e. Street and Number 50l Main Street #			Zip Code 20707		Og. Citizen of What C	
ours after de ral', or Items Examinar in	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	<ol> <li>Was Decedent Ever in U. Armed Forces?</li> <li>1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:</li> </ol>		ecedent of Hispanic Origin? specify Cuban, Mexican, Pu s 2 X No Specify:	(Specify Yes of No- erto Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	
within 72 no ene. than "natu he Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1.2		life. DO NO	Usual Occupation I work done during most of v Tuse retired) e Secretary	vorking	16b. Kind of Business National F Associatio	Rifle
ould be tited Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Ernest Alfred Ken	t	1	18. Mother's N	lame (First, Middle, I		
permit. Pages 1 and 2 should be filed within 72 hours affer death with the maryland Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or Items 23s or 28s-f show any in ury or other traumatic event, the Medical Examinar must be notified at one.		19a. Informant's Name/Relationship (Ty)  Kirk C. Birdsong  20a. Method of Disposition  1□Burial 2 ⊠Cremation 3□R	/ son		ress (Street and Number or nterbury Ridi Name of or other place)	.ng, Laure		nd 20723
permit Pag Department Importent: I any in ury o		4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	W.	22. Nam Dona	rematory Aug and Address of Facility Idson Funeral Talbott Ave.	Home, P.	Α.	
hysician /Medical	V. 7.	23a. Part 1. Enter the risk two, or compliance, or hear failure. List only on Immediate Cause (Fmat disease or condition resulting in death)	The second second	n. Do not enter the				Approximate Interval Between Onset and Death
xaminer	iner	Sequentially list conditions, if any, reading to introduce cause. Enter Underlying	Cardiomyopa	thy				10 years
ite be executed tysician and he burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	ASVD  Due to (or as a consequent to the state of the stat					15 years 25 years
ar death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time et de 9 □ Unknown	Ideath 3□Ectop	ic pregnancy (specify)		23d. Date of de Month	elivery Day Year
n signed b	þ	Part II. Other significant conditions con	tributing to death but not rest	ulting in the underlyi	ng cause given in Part I.		**	to the cause of death? Probably 4 []Unkno
ate has bee page 2 sho	Completed					24a. Was a autops perform	sy prior to	
ertific ector,	Be	25. Was case referred to medical examiner?				Death Check only on	-	
n. After this o funeral dire	on: To	1 ☐ Yes 2 🖔 No  27. Manner of Death 1 🖔 Natural 5 ☐ Pending	ospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	28c. Injury at Work?		ence 6 Other (Spoow injury occurred	ecify)
	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		1 Yes 2 No	28f. Location (SI City or Town	treet and Number or F n, State)	Rural Route Number,
within 24 hours after the transparent of the Funeral Direction of the funeral Direction of the funeral filted in the funeral of the funeral filted in the funeral filted in the funeral filted in the funeral filted in the funeral filted in the funeral filted in the funeral filted in the funeral filted in the funeral filted in the funeral filter	edical C	29a. Certifier 1½ Certifying Phys (Check only 2 Medical Examir one)	ician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death occur tion and/or investiga	red at the time, date and plation, in my opinion, death oc	ace, and due to the courred at the time, d	ause(s) and manner a late and place, and du	as stated. se to the cause(s)
withir To th comp	M	29b. Signature and title of certifier	oron his	£50,	29c. License number H0059310		9d. Date signed (Mon	
20		30. Name and address of person who co			ark Drive, #2			
Sta Registr		31. Date filed (Month, Pay, Year) AUG 3 0 200					-, maryran	20101

		For State Registrer  1. Decedent's Name (First, Middle		State of Ma		Cei	tificate of	Death	2. Date of	Reg. I		00	2740
Physicia		Marie A. Voles	, Lasi/						Month Augu		5, 200	Year 6	8:15 PM M
/Medica Examine		4a. Facility Name (If not institution, Casey House	give st	reet and number)			4b. City, Town, o	Derwood			4c. County o		У
Funeral Director		5. Social Security Number 092-18-5047	6. Sex 1 □	7. Age	(In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days		8. Date of (Month 08/1	Birth Day, Yes	ar) 2 4	9. Birthp Cour <b>MI</b>	lace (State or Foreign try)
ryland		Usual Residence of Decedent  10a. State 10b. County			10c. City, To	own or Lo	cation					1	0d. Inside City Limits
he Ma	ecto	MD Monto	ome	ry	Olne	У	1			1.0	O:::		1 ☐ Yes 2 🗷 No
death with the Maryland rns 23a or 28a-f ehow Eriust be notified at	ai Dir	10e. Street and Number 3216 Spartan Ro	1. #	38			10f. Zip Code 20832-	-			Citizen of Wi nited		•
ig # 2	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Marri 3 □ Widowed 4 □ Divorced		2. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1	Vas Decedent of N Yes, specify Cub ☐ Yes 2 No		(Specify Yes or lerto Rican, etc.	No-		, White,	
1215-0 vithin 72 ho ne. han "natur	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education	ation completed) College (1-4or 5+	-)	(Give life. l	ent's Usual Occup kind of work done DO NOT use retire nasing Ac	during most of v d)	working		Kind of Bus		dustry
Baltimore, Maryland 21215-0036 permit. Pages I and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. mportant: if Item 27 is marked other than "natural", or my Injury or other traumatic event, the Madical Examples.	To Be Co	17. Father's Name (First, Middle, Basilio Valen					<b>-</b>	18. Mother's N	Name (First, Mic nnina V			)	
Mary and 2 should be able to a straumai		19a. Informant's Name/Relationsh Maria Ferguson/			1		g Address (Street Pomande						
Pages 1 armone of He tant: If item jury or oth		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 4 ☐ Donation 5 ☐ Other (Sp			Ches	sapea	sition (Name of natory or other pla ke Crema	210	Date gust 28 2006		Location - C	-	wn, State Maryland
Ball permit Depart Import any in		21. Signature of Funeral Service-	1 (/	hman	n00382		Name and Addre Lapp Fune: 33 Gist		emation lver Spr			ınd 2	0910-
Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)		ations that caused to cause on each line	the death. D o. ute My	relog	er the mode of dyi		liac or respirato	y arrest,			Approximate Interval Between Onset and Death
68760, Etificate be executed g physicien and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. c. d.	Due to (or as a									
<b>W</b> = 0.6	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23	c. If yes, outcome o 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal dea		Ectopic pregnanc	y		_	23d. Date Mont		ory Day Year
rds, P. quires that	۾	Part II. Other significant conditio	ns cont	nbuting to death but	not resulting	g in the u	nderlying cause giv	ven in Part I.					ne cause of death? ably 4 □Unknown
Division of Vital Records, I or Attending Physician: The law requires that death.  Director: After this certificate has been signed in by the funeral director, page 2 should be de	Completed								P	vas an utopsy erformed s 2 🛣	? de	ere auto lor to con ath? Yes	psy findings available inpletion of cause of
Vita	Be	25. Was case referred to medical examiner?	Н	ospital:			Ott		Death (Check or				1/
On of ading Physis: After this stuneral di	itlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investig	<u> </u>	1 ∐ Inpatien 28a. Date of Injury (Month, Day	t 2 □ ER/0 Year) 28t	D. Time of Injury	28c. Inju	ry at			6 MOther		) HOSPICE
Division of Vital Rec To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could r 4 Homicide determi	ot be	28e. Place of Injur building, etc.	ry - At home, (Specify)	, farm, str	eet, factory, office		28f. Locatio City or	n (Street Town, St	and Number ate)	or Rura	l Route Number,
ne Hospit 124 hour ne Funera tetely fille	Medicai (	29a. Certifier 1 ☑ Certifyin (Check only one)	g Physi Exemin	cien: To the best of er: On the basis of e and manner state	examination	dge, death and/or in	occurred at the ti restigation, in my o	me, date and pla opinion, death or	ace, and due to ccurred at the tir	the cause ne, date a	o(s) and man and place, ar	ner as st nd due to	ated. the cause(s)
To th withir To th comp	M	29b. Signature and title of certifier  Cynikia W		Villion	no Do	0	29c. Licens				Date signed	1	
8		30. Name and address of person of C.M.Williams, D	who con	mpleted cause of dea Montgome	ath (Itom 23a ery Ho	SPICE	Print) COOIMU	incaster	- Mill R	d Ro	ckville	MI.	20855
Stat Registra		31. Date filed (Month, Day; Year)  AUG 3 0	2008	32 Degistrar		A							

			Registrer	23talper Mary	<b>10858 908</b> Ce	ABO (USANIS rtificate of	lealth and N Death		iene 2006 <sub>93. No.</sub>	27406
I	Physici /Medic		Decedent's Name (First, Middle, La Mary     C.	•	nuto			2. Date of Death Month August 2	Day Year	3. Time of Death 1:35 P <sub>M</sub>
	Examir		4a. Facility Name (If not institution, gir Williamsport Nurs		ed Living		r Location of Death		4c. County of Death Washingto	
	Funeral Director		-	Sex 7. Age (In 1	yrs. last birthday, 93 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Pay, August	111, 1913 g. Birth	place (State or Foreign ntry) yland
	Maryland a-f ehow	tor	10a. State 10b. County Maryland Morgan	100	: City, Town or L Berkel	ey Spring	gs			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the 3a or 28	I Director	10e. Street and Number			10f. Zip Code	1	10	0g. Citizen of What Cou	ntry?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examinat	by Funeral	4979 Piousridge F  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		2541 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 □XNo		ecify Yes or No- Rican, etc.)	USA  14. Race - Ameri Black, White  Specify: Wh	
Maryland 21215-0036	d within 72 ho giene. er than "natur i fre Madicel.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 6 Years	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occupi b kind of work done of DO NOT use retired	during most of work	ing	16b. Kind of Business/Ir Own Home	ndustry
and	d be filed ental Hygi ced other c event, II	Be	17. Father's Name (First, Middle, Last Anthony Ambrosett	•				e (First, Middle, M		
Aaryl	2 should be and Mental is marked raumatic ev	2	19a. Informant's Name/Relationship	Type, Print)			and Number or Rur	al Route Number,	City or Town, State, Zij	
ore, 1	ges 1 and 2 t of Health If item 27 or other tru		Robert Venuto  20a. Method of Disposition  1   1   2   1 Cremation 3   1	Pomoval from State	Db. Place of Dispo cemetery, cre	osition (Name of matory or other place	a) Augu	Date 28,	Springs, W	own, State
Baltimore,	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other in		4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funaral Service Lice	(y)		Faith Cemete 2. Name and Addres Onnelly F	20	06 R	osedale, Ma undalk,P.A. undalk,MD.	_
	<u>40</u>	St 7.	23a. Part1. Enter the disease, or comshock, or heart failure. List only	iplications that caused the						21222 Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cor	Asp	oiration H				Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, I are leading to mind accuse. Enter Underlying Cause (Disease or injury that initiated events	b. Due to for as a cor	100					Tagy-
68760,	ficate be executed physicien and s the burial-transit	edical Exa	resulting in death) Last	Due to (or as a cor	nsequence of):					
P.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome of pri 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year
ords, P	equires that en signed to ould be deta	þ	Part II. Other significant conditions of Renal Fallur.	h 1	resulting in the u	,	en in Part I.	23e. Did toba	acco use contribute to the	
Division of Vital/Records,	The la	Completed	Diabetes Me Staphylococca	Mound	Inf	ection		24a. Was an autopsy perform	ed? prior to co	psy findings available mpletion of cause of
VITE	yeician: is certific director,	o Be	25. Was case ret rred to medicat examiner? 1 ☐ Yes 2 No	Hospital:	2 ☐ ER/Outpatier	0.00	26. Place of Death		nce 6 Other (Specif	u)
sion 6	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	atlon: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of	28c. Injury Work		28d. Describe how		<i>,</i> ,
<u>X</u>	tal or Att	Certification:	3 Suicide 6 Could not b 4 Homicide determined		At home, farm, str ecify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,
	the Hospi in 24 hou the Funer	ledical	one)	nysicien: To the best of my niner: On the basis of exan and manner stated.	knowtedge, death	vestigation, in my op	inion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as s te and ptace, and due to	ated. the cause(s)
,	Towitt	Σ	29b. Signature and title of certifier  Cynthia K	uttren-Sa	nds, rs	29c. License	7451	A	d. Date signed (Month,	4,2006
	(0)		30. Name and address of person who Cynthia Kuthner	completed cause of death	Item 23a) (Type,	Print) sport	Narsin	g Home,	154 Nor	& Artizan
	Sta Registra		31. Date filed (Month, Day, Year) AUG 3 0 2006	32. Registrar's S	ignature	7	aci, w	TITELYNS	port, Mag	rand

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

amend Item 19a per fth 9858 8-30-06 vt.
State of Maryland / Department of Health and Mental Hygiene 2006

27407 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year **Physician** 8 23 2006 0 545 a<sup>M</sup> Williams Rose Marie Jones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caton Manor N/A Balto If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9-18-1954 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F Yrs. Director 218-64-6708 51 Md Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28s-f show ir then "neturel", or items 23a or 28s-f ehov The Medical Examiner must be notified at 1X Yes 2 □ No Director Md N/A Balto 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2209 Allendale Road 21216 USA Funerai Pages 1 and 2 should be fited within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Black Specify: Completed by 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+)
N/A Elementary/Secondary (0-12) 10th grade Housewife Home permii. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if item 27 is marked other th eny injury or other treumatic event, I'll ODEB. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Jones June Jones ၉ 19a. Informant's Name/Relationship (Type, Print) **Daughter** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2209 Allendale Road Linda Johnson - Mother Balto, Md 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 8/28/2006 Catonsville, Md 4 □ Qonation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West Rome JKW. ppon 4300 Wabash Avenue Balto, Md 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of) Examiner Alos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires thet the death certificate be executed HIV physicien ar Due to (or as a consequence ol) Division of Vital Records, P.O. Box 68760, Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ete hes been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 1 Natural Injury 5 Pending death. i Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funeral Dire filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medicai The Certifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062634 29/6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMDIA MD 21044 MATEEN AWAN 10802 HICKORY RIDGE RD 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006 27408 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 8 25 2006 4:30a Lucy Willis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4614 Charles Avenue 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F 220-36-4633 Vrs Director 93 S.C. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow ir than "naturel", or items 23a or 28a-f ehov the Madical Examinar must be notified at 1√2 Yes 2 No Baltimore Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4614 Charles Avenue 21206 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ል Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Other people homes 6th grade 17. Father's Name (First, Middle, Last) other 18, Mother's Name (First, Middle, Maiden Sumame) and Mental ie marked Frank Rawls Ella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heelth ar Important: If Item 27 to any injury or other trau Samuel Willis 4614 Charles Avenue, Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Cem. 8-29-06 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 w ane March F.H. East 1101 E. North Ave 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Dehydration
Due to (or as a consequence of): /Medical Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Records, P.O. Box 68760, physicien Physician/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 dunknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No was -. autopsy performed? Yes 2.2 No hes 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ۵ 4 Homicide C within 24 hours after To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0059388 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Weismay Baltimore MO Blud. Loch Roce 5601 32. Registrar's Signature AUG3 0 2006 State Marchan Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUGUST 28, 2006 2006 Physician MORTON YABLONSKY 8:30 A M Μ. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR CARE FALLS ROAD BALTIMORE N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth **Funeral** Months Days Hours 1 M 2□ F 0971771935 PA 159-30-9561 70 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location other then "natural", or items 23s or 28s-f show vent, the Madical Examiner must be potified at 10d. Inside City Limits BALTIMORE COCKEYSVILLE 1 ☐ Yes 2 X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1006-C MISTY LYNNE CIRCLE 21030 USA Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🂢 No WHITE ģ Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MERCHANDISE MANAGER WOMEN'S CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be to Department of Health and Mental Himportant: If item 27 is marked ot sny lightry or other traumatic even 2008. YABLONSKY COHEN BESSIE JOSEPH. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 83 SWANTON MEWS #200 - GAITHERSBURG, MD 20878 BART YABLONSKY / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MT. LEBANON CEMETERY 08/29/2006 COLLINGDALE, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Scatt 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician ALCOHOLIC LIVER CIRMOSSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner I-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien a Completed by Physiclan/Medical ettending pl IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 DEctopic pregnancy Month 4☐Pregnant at time of death signed by the e 5 Other (specify) 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 055 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete hes t irector, page 2 s o the Hospital or Attending Physician: after death.

Director: After this certification by the funeral director. 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 \( \oldsymbol{N} \) Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a
To the Funerel C 12 Certifying Physician: To the heat of my knowledge. Seath operated at the time, date and place, and due to the cauca(c) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0054107 M. 0 n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 BUSINESS GNTER REISTERSTONN Mr 21136 UMA DRIVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 3 0 2006

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 1 - For State Registrar 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Harold William\_Brown 2006 9:30 A August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gladys Spellman Specialty Hospital Prince George's Cheverly 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2 □ F Yrs. Director 69 May 10, 1937 226-44-1473 Virginia Usual Residence of Decedent with the Manyland 10a, State 10h County 10c. City. Town or Location 10d. Inside City Limits **ahow** in than "natural", or items 23a or 28a-1 ahov Ite Medical Examinar must be notified at 1 XYes 2 No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5852 Southern Ave., SE 20019 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6th Truck Driver Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be filment of Health and Mental H tant: If item 27 is marked ot th and Mental F. Unknown Ida Mae Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8914 Palmer St., Ft. Washington, MD other Victoria Milton/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or ŏ 8/12/2006 Woodberry Cemetery Gordonsville, VA 4 □ Dopation 5 □ Other (Specify) of Fyrneral Service Licensee 21. Signatur 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C.L. se (Final disease or condition resulting in death) **Physician** Multiple Strokes /Medical Due to (or as a consequence of) Examiner Hypertension

Due to or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit Seizure Disorder Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical Chronic Obstructive Lung Disease IF FFMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 certificate 2 X No 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? CertIfication: 28d. Describe how injury occurred 1 XNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No efter death Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital within 24 hours e To the Funeral C Hospital 124 Certifying Physician: To the best of my knowledge death accurred at the time, date and place, and due to the equation; and marrier as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ame and address of person who completed cause of death (Item 23a) (Type, Print) Ophnell Cumberbatch, M.D. 8416 Central Ave., Capitol Heights, MD 20743 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State AUG 1 4 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene, 06 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Katie QueenEsther Brown 2006 8:15 A August /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's 2104 Shadyside Ave. Suitland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🔀 F Yrs. Director 213-32-8025 Maryland 89 Oct. 19, 1916 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r then "natural", or Iteme 23a or 28a-f show the Medical Examinar must be notified at 1 XYes 2 ☐ No Prince George's Maryland Suitland [ ] Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2104 Shadyside Ave. 20746-4808 United States filed within 72 hours after death v Hygiene. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify. ģ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Depertment of Health and Mental Hygiens Important: if item 27 le marked other the eny Injury or other traumatic event, I.a.t. 2008. Government 6th Dietitian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maude Jones William Savoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Queen Esther Scott/Daughter 2104 Shadyside Ave., Suitland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 8/8/2006 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 was 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Congestive Heart Failure **Physician** /Medical Due to (or as a consequence of): Examiner Arrythmia Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit Paroxysmal Atrial Fibrillation that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2XX No 3 ☐ Probably 4 ☐ Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? History of Stroke hes autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending 1 Tes 2 No М investigation 2 Accident filled in by the Director 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Funeral 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Hawani Lember 13

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D46576 106 Hawani Temesgen, M.D. 6104 Old Branch Ave., Temple Hills, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State

DHMH 17 Rev 1/2001

Registrar

1 4 2006

	ı	1 - For State of Maryland /	•	rtment of He		Mental Hyg	giene 199. n <mark>2</mark> 0 0 6	27412
	A.	Decedent's Name (First, Middle, Last)			-	2. Date of Dea Month		3. Time of Death
Physic /Med	4.00	Virgil Gerard Biag	as			AUGUS		
Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L		1	4c. County of De	
		Doctors Community Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last t	highday	Lanham	If Under 24 Hrs.	8. Date of Birth		Georges inthplace (State or Foreign
Funeral Director		438-92-6217 1X M 2 F 49	Yrs.	Months Days	Hours Min.	(Month, Day October	r, Year)	ouisiana
		Usual Residence of Decedent				0000002	0,1330	
arylar ehow	_	10a. State 10b. County 10c. City, To						10d. Inside City Limits 1X Yes 2 ☐ No
the M	Director	Maryland Prince Georges Mi  10e. Street and Number	tche	11ville			10g. Citizen of What	
with Sa or		14400 Danube Lane		207	21		United St	
death me 23	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of Hisp Yes, specify Cuban,		pecify Yes or No-		nerican Indian,
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or teme 23a or 28a-f show aumatic event, the Mudical Examinar Invate inclitical at	by Fur	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give  3 Widowed 4 Norced Year or Dates:			Specify:	o Alcan, etc.)	Specify: B	
2 hou	ted	15. Decedent's Education 16		ent's Usual Occupati		460	16b. Kind of Busines	s/Industry
215 Thin 7	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life. [	kind of work done du 20 NOT use retired)	ring most or wor	king		
ed will	Con	12th grade	E1	ectrician			Construc	tion
Maryland 21215-0036 Id 2 should be filed within 72 hours ali lith and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, tre Mudical Exercit	Be	17. Father's Name (First, Middle, Last)  Alvin Joseph Biagas, Sr.		'	Veda	Arsot	Maiden Sumame)	
lore, Maryla ges 1 and 2 should t of Health and Mer if Item 27 is merke or other traumatic	2		9b. Mailin	g Address (Street an			r, City or Town, State	, Zip Code)
M6		•	4400	Danube La	ane: Mit	chellvil	lle, Maryl	and 20721
or He	1 1	20a. Method of Disposition 20b. Place	of Dispo	sition (Name of natory or other place)	1.5	Date	20c. Location - City CLake Cha	or Town, State
altimore, mit. Pages 1 ar partment of Hea portant: If Item: y Injury or other		1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Cons		a Cemetery		12,2006	Louisi	ana
Baltimore, Ma permit. Pages 1 and 2 st Department of Health at Important: If Item 27 Is eny Injury or other trau gace.		21. Signature of Funeral Service Licensee	22 R 6	Name and Address No Hort No Kenned	of Facility on Compa y Street	any Mort	icians, In	D.C.20011
8		23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not ente	er the mode of dying,	such as cardiac	or respiratory arr	rest,	Approximate Interval Between
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/Medical Examiner	1	resulfing in death)  Due to (or as a consequence	e of):		*			
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38760, icate be executed physician and s the buriat-transit	dicai	d						
C 68	Med	IF FEMALE:						
Box 61 death certific eath certific eath certific	lan/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea		Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
, P.O. I that the de ed by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	ع ا	Other (specify)				
S, P,	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting	g in the ur	nderlying cause given	in Part I.	23e. Did to	bacco use contribute	to the cause of death?
cords w requires been sign						1 🖭 Ý	es 2 🗆 No 3 🗆	Probably 4 Unknown
	Completed					24a. Was a		autopsy findings available o completion of cause of
of Vital Re Physicien: The la r this certificate has	Com					perfor	med?/ death	s 2□ No
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Of Of Physical Physic	2		Outpatien  o. Time of		4   Nursing F		lence 6 Other (S)	pecify)
ding h. After funer	tion	1 Latural 5 Pending (Month, Day Year)	Injury	28c. Injury : Work? M 1 7	es 2 No	200. Describe II	ow injury occurred	
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Division or To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai (	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowled and manner stated.	dge, death and/or inv	n occurred at the time restigation, in my opin	, date and place nion, death occu	, and due to the d irred at the time, o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
To the within 2 To the complet	₩ W	29b. Signature and title of dertifier		29c. License		1	29d. Date signed (Mo	,
		/ www		b 35	941		8/9,	106
(10)		30. Name and address of person who completed cause of death (Item 23:	K 150 A	WAY SO	172 20	2 Mito	H51 LV/LL	E HD20721
Si Regis	ate trar	31. Date filed (Month, Day, Year)  AUG 1 5 2006  Registrar's Signatura	he	Bi				, , , , , , , , , , , , , , , , , , , ,
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State of Maryland / Department of Health and Mental Hygien 2006 274 3

			1 - State Registrar		Ce	rtificate of	Death	R	eg. No.	0 2/4/3
	Dhi.i		1. Decedent's Name (First, Middle	, Last)				2. Date of Deat Month	th	3. Time of Death
П	Physici /Medio		MIRIAM INEZ B	JRNEY				August	6 200 E	6 7:35 a м
	Examir		4a. Facility Name (If not institution	, give street and number;	)	4b. City, Town, o	or Location of Death		4c. County of I	Death
			Manor Care			Silver S	1 0		Montgo	
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birthday) 95 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director		255-54-1488 Usual Residence of Decedent		75 118.			Dec. 14	, 1910	~Georgia
	rland ow		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Man,	ğ	MD Montgo	omery	Silver S	pring				1 ☑ Yes 2 ☐ No
	r 28s	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	t Country?
	th wit	a D	8607 Sundale Ro	i.			20910		USA	
	ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		American Indian, White, etc.
92	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show he Medical Examinar must be rotified at	y Fu	1 Never Married 2 Marri		No	1 ☐ Yes 2 ☑ No	Specify:	Tiloan, otc.)	C===:4::	
21215-0036	hours urai',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:						Black
7	n 72 • nat	Completed	15. Decedent (Specify only highes	s Education t grade completed)	16a. Dece (Give	dent's Usual Occup kind of work done	pation during most of work d)	ing	16b. Kind of Busin	ess/Industry
2	withi ene. then	Ę	Elementary/Secondary (0-12)	College (1-4or	5+)	memaker	0)		Private	2
0	filled Hygi other	Ç	17. Father's Name (First, Middle, I		110	memarer	18. Mother's Nam	e (First, Middle, M		
<u>a</u>	ould be filed v Mental Hygie varked other t	To Be	Samuel Cunning	gham			Belle Ja	ackson	,	
Maryland	동민토토	-	19a. Informant's Name/Relationsh	nip (Type, Print)	19b. Maili	ng Address (Street	and Number or Run	al Route Number,	, City or Town, Sta	te, Zip Code)
	1 and 2 Health a lem 27 is		Belva Burney Pe	ettiford/Dau	ighter 8607	Sundale	Rd. Silve	er Sprin	g, MD 209	910
altimore,	es 1 ar of Hea fitem r othe		20a. Method of Disposition	- 5-	20b. Place of Dispo	osition (Name of matory or other place	ce)	Date	20c. Location - City	or Town, State
Ĕ	Pages nent of int: if it iry or o		1 Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (St		South-Vi			11,2006	Atlanta,	Ga.
ā	permit. Pages Department of Important: if it any injury or c		21. Signature of Funeral Service I	ісеряее	/ 22	2. Name and Addre	ss of Facility Jol	nnson and	d Jenkins	Funeral Home
m —	89 = 9		Jasel	5 Juns	per 7	16 Kenned	ly St. NW	Washing	ton, DC 2	20011
			23a. Part 1 Enter the disease, or shook, or heart failure. List	complications that causer only one cause on each li	d the death. Do not entine.	ter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	PNEUMONI	A					Onset and Death 4 weeks
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
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_	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c.	a consequence of):					
9	be e sician buria									
68760	certificate be executed rding physician and ise as the burial-transit	/Medical		d						
ŏ		/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of	delivery
n	death of attended for up	Physician	in the past 12 months?	4□Pregnant at		]Ectopic pregnancy ] Other (s <i>pecify)</i>	′		Month	Day Year
J.	t the by the ache	hys	9 Unknown	9□ Unknown						
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ğ	w require been sig should b	edt	ALZHEIMER DEMI	ENTIA				1 □ Ye	ıs 2. <mark>X</mark> No 3. □	Probably 4 Unknown
ecords,	awre is be	Completed						24a. Was ar	n 24b. Were	autopsy findings available
r	0 5 0	E						autopsy perform	y prior death No 1 🗆	to completion of cause of h? Yes 2 <b>X</b> No
VItal	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of Death			
010	dis is	To	1 ☐ Yes 2 XNo	Hospital: 1  Inpatie	ent 2 ER/Outpatien	nt 3□ DOA Oth	er: 4X Nursing Ho	me 5 Reside	nce 6 Other (5	Specify)
	<b>5 6</b>		27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time of Injury	28c. Injur War			w injury occurred	
<u> </u>	tendi leath. tor: A the fu	catl	2 Accident investig 3 Suicide 6 Could n	ation		M 1 🗆	Yes 2□No			
DIVISION	al or Attending after death. I Director: After d in by the funes	Certification;	4 Homicide determi	ned   289. Place of III]	ury - At home, farm, str c. <i>(Specily)</i>	eet, factory, office		28f. Location (Str City or Town	reet and Number of , State)	r Rural Route Number,
_			On Continue W Continue	District Total						
	e Hospitai 24 hours e Funerai letely filled	dica	29a. Certifier 1 A Certifying (Check only 2 Medical E	Physician: To the best examiner: On the basis of	t examination and/or inv	n occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurr	and due to the ca ed at the time, da	iuse(s) and manne ite and place, and	r as stated. due to the cause(s)
	To the within 2. To the complet	Medical	29b. Signature and title of certifier	and manner sta	a16U.	29c. Licens			9d. Date signed (M	
	F 3 F 8		BONN	MM.	1	D37				
	1		30. Name and address of person v	who completed aguar of	leath (Itom 22a) (Tre-		71 <b>)</b>	A	August 9,	2000
	(3)		Jeffrey P. Indo		.0801 Lockw		#280 Sil	lver Spr	ing, MD 2	20901
	Sta	te	31. Date filed (Month, Day, Year)						0,	
	Registr		AUG 1 5 20	186 Ban	ar's Signature	w				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006Registrar #10b, per funeral home, 8/17 Getificate of Death D.H. WCHD Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:45 BILLINGSLEY 2000 PATRICK 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death SOUS SOUN 028721 SPILL HINE DMIC 8. Date of Birth (Month, Day, Year 3-21-1964 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days Min 1**☆**M 2□F 42 MARYLAND Yrs. 215-94-2572 Usual Residence of Decedent 10b. County WORCESTER 10a. State 10c. City, Town or Location 10d. Inside City Limits OCEAN CITY **WICOMICO** MARYLAND 1€ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? UNITED STATES 21842 126 135th STREET 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done du life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION SUBCONTRACTOR 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SHIRLEY F. RODDA JAMES BAIRD BILLINGSLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 135th ST., OCEAN CITY, MARYLAND 21842 PATRICIA A. BILLINGSLEY/WIFE 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State CAPE HENTOPEN of place)
CREMATORY 3 Removal from State 8-16-2006 Burlai 2 Cremation FRANKFORD, DELAWARE Donation Other (Specify) 2 . Signature of Fonera MELSON FUNERAC SERVICES, LTD. 43 THATCHER ST., FRANKFORD, DE 19945 23a. Part1. Enter the dise shock, or heart failu e. Enter the disect e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest c, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) retastatic Cancre Sacurately ist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗆 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only dee) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes ENO. 2 ER/Outpatient 3 DOA 27. Manner of leath 28d. Describe how injury occurred Natural

/Medical Examiner physicien and the burial-transit The law requires that the death certificate be executed Box 68760, nding f P.O. the signed by the Division of Vital Records, been si should

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or itsms 23s or 28s-f show anaber must be notified at

'natural'

Director

Funeral

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Completed

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with the Maryland

Pages 1 end 2 should be filed within 72 hours after death

and Mental

f Health

permit. Pages 1 Department of H Important: If Ite any Injury or ot ance.

Physician

Baltimore, Maryland 21215-0036

Exam Physician/Medical Completed by certificate has t irector, page 2 s Be ဥ After thi Medical Certification: the t

∠ □ Accident 3 Suicide 4 Homicide 29a. Certifier

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28b. Time of

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the natise(s) and marker as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	00
(1) 105	- //////
1/3/1/	011

29c. License number ス6 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed caus of death (Item 23a) (Type, Print) parter

31. Date filed (Month, Day, Year) State AUG 1 7 2006 Registrar

BUX 1733

DHMH 17 Rev 1/2001

To the Hospitel or Attending Physician:

death.

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within 24 hours eft To the Funerel DI completely filled in

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 27415

		1- For State Registrar		Certific	cate of I	Death			Reg. No.		
Physicia		1. Decedent's Name (First, Midd.	e,Last)	<del></del>				2. Date of D			3. Time of Death
ledical Exami		Robert Kevin	Brown					Month August	22, 2006	Year	0959 hrs
		4a. Facility Name (if not institution		umber)	46	. City, Town, or Lo	cation of Death			inty of Death	1
		Civista Medical Cente				LaPlata			Char	-	
- E		Social Security Number	6. Sex	7. Age (In yrs. last b	urthday/	If Under 1 Year	If Under 24Hrs	8 Data of			thplace (State or
Funeral	-				ii ii iuay)	Months Days	Hours Mir	_	,	Foreig	n Now
Director		056-46-9952	1 X M 2 F	53	Yrs.	Days	, , con o	May	14, 195	3   00	untry) ew
	ı	Usual Residence of Decedent									
any		10a State 10b. County		10c. City, Tow	n or Location	n					10d. Inside City Limits
<u>*</u> ,		Manuland Chanle	2.6		Wald	onf					1 Yes 2 X No
Aaryland 28a-f show 1 at once.	윘	Maryland Charle 10e. Street and Number	= 3			10f. Zip Code			10g. Citizen o	f Mhat Cau	ntn/2
Mar r 28;	Director					,					iti y :
ith the Maryland 23a or 28a-f sho	≅∣	6954 Cony Cour	rt		i	20	0603			USA	
with ms 2	eral	11. Marital Status		cedent Ever in U.S.		Decedent of Hispa					ican Indian, Black,
leath r ite	Š	1 Never Married 2 M	arried Armed F	2 No	li Tes	s, specify Cuban, M	viexican, Puerto	Rican, etc.)	l v	White, etc.	
fter (Fr.)	ᄔ	3 X Widowed 4 Div	orced If Yes, Give Ye	ar 1975-84	1 1	res 2 X No	specify:		Spec	cify:	White
0036 within 72 hours at tiene er than "natural Medical Examin	d b	15. Decedent's Education (Spe				S Usual Occupation		work done	16b. Kind o	of Business/I	
2 hou "nat	ompleted	Elementary/Secondary (0-12)	College (	1-4 or 5+)	during mos	st of working life. D	O NOT use ret	ired)			,
136 hin 72 e than	픮	_ , , , , , ,	1		Compus	tor Space	ialic+		lus c	overn	mon+
5-0036 filed within 7 Hygiene d other than the Medical	등	17. Father's Name (First, Middle			Compa	ter Spec		/F:4 M/-I-II	e, Maiden Surna		nent
Hyg d of	ပေျ		,			1				,	
121 I be fi ental I arked vent,	Be	Donald A. Brow							phine C		
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner, must be notified at once	욘	19a. Informant's Name/Relations		100		Address (Street a					
MD d 2 sho lith and n 27 is		Christopher M.	Brown -	Son []1	.2270-1	G Green M	Meadow	Dr., C	olumbia	, MD :	21044
Heal Tra		20a Method of Disposition				on (Name of ceme	tery,	Date	20c. Locat	on - City or	Town, State
D C C C C C C C C C C C C C C C C C C C		1 Burial 2 Cremation			atory or othe		200	E 2006	Cho1+	anham	MD
timen trant		4 Donation 5 Other S				s' Cemete					
Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Med		21 Signature of Funeral Service	. / 13 /	M00053	22. Na	me and Address o	f Facility	3035	01d Wa	shing	ton Rd.
<u></u>			Whaw								, MD 20604
Physician		23a. Part I. Enter the disease, or railure. List only one cause		caused the death. Do	not enter the	mode of dying, su	uch as cardiac	or respiratory	arrest, shock, o	r heart	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease		ensive athero	rec1erot	ic cardio	eculer i	dienaen			Death
Examiner		or condition resulting in death)		a consequence of):	A CICIO	LIC CHICION	ascurar (	iiiscasc			
		Sequentially list conditions,	b.								
	ē	if any, leading to immediate	Due to (or as	a consequence of):							
	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated	С								1
_ = :=	xai	events resulting in death) Last	Due to (or as	a consequence of):							
cute and trans			d								
.8760, rificate be executed ng physician and as the burial - transit	sician/Medical	XUNPENDED	AMENDED	item#23a,PI	TT 27 TX	∞ME C950 0	/1 /2006 1	יויי			
8760, tificate be ng physic as the bur	Me	IF FEMALE:	23c. If yes,	outcome of pregnance		Trib,0009,9	/1/2000	r r	23d. Dat	te of delivery	
<b>∞</b>	=	23b. Was decedent pregnant in the past 12 months?			2 Feta	I death 3	Ectopic pregn	ancy	Mont	,	Day Year
x 6 h cer tendi	:5			nant at time of death		er (Specify)					
Box 6	ıys	1 Yes 2 No 9 Un	known 9 Unkr	nown					j		
Division of Vital Records, P.O. Box 6 the Hospital or Attending Physician: The law requires that the death cerbin 24 hours after death the Funeral Director: After this certificate has been signed by the attending reletely filled in by the funeral director, page 2 should be detached for use	Phys	Part II. Other significant condit	tions contributing	to death but not result	ing in the un	derlying cause giv	en in Part I	23e. Di	d tobacco use c	ontribute to	the cause of death?
res that the signed by I be detached	ρ	Diabetes Mell:	itus					1 -	Yes 2 ✓ No	3 Prot	oably 4 Unknown
Januare Autore	Completed		LCus		_			24a. W			. –
ords w requires to been should	e								topsy		topsy findings available completion of cause of
ec he la tte ha	Ĕ							pe 1 ✓ Ye	rformed? s 2 No	death? 1 ✔ Ye	es 2 No
tal Rec ician: The certificate rector, page		25. Was case referred to medica	it I			26 Place o	f Death (Check		3 2 110		75 2 140
Division of Vital Records, ral or Attending Physician: The law requires after death all Director: After this certificate has been seled in by the funeral director, page 2 should the	Be	examiner?	Hospital:	Innationt 2 - FDI	Outpotiont		thos		7.0	0 00	
F Vid	P	1 ✓ Yes 2 No 27. Manner of Death		Inpatient 2 ER/				ng Home 5			
Ing Ph After 1 funeral	Ë	1 X Natural		e of Injury th, Day, Year)	b. Time of Inj		_	28d. Descrit	oe how injury oc	curred	
in tend tend the the	iž	J Pen	ding stigation			1 Ye	s 2 No				
/iS r At ter d irec	Ę			ce of Injury - At home,	farm, street	factory, office bui	lding, etc.			umber or Ru	iral Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification		rmined (Specify	)				or Towr	ı, State)		
losp t hou une		29a Certifier	hysician: To the he	est of my knowledge, o	death accurre	ad at the time, date	and place, and	due to the e			to d
he h in 24 he F	ica			of examination and/o							
Divis To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	Medical		and manner								
	2	29b. Signature and title of certific	*			29c. License					nth, Day, Year)
		my a	i, mi	,		O.C.M	.E.		August	23, 2006	
0		30. Name and address of person	who completed cau	use of death (Item 23a	a)						
B			int Medical Exa			, Baltimore, M	D 21201				
עוציי	tate			4							
Regis		31. Date filed (Month, Day Year)	4 2006	Istrar's Signature	An	de					
- Nogio	14.1										

			For State Registrar	State of Marylan	d / Depa <i>Ce</i>	artment of H <i>rtificate of L</i>	ealth and M Death	1ental Hygid Reg	2006	27416
ī	Physicia	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	David Wesley  4a. Fecility Name (If not institution, give	Bramell		4b. City, Town, or		August	15 2006 4c. County of Deat	6:20 a <sup>M</sup>
	Examin	er	5720 Ripley Pa			LaPlat			Charles	
Ì	Funeral Director		21, 31 0110	ex 7. Age (In yrs. 69	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, gust 16	,1936 °C	thplace (State or Foreign punity) Inginia
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	a-fsh	ctor	MD Charle	s	La I	Plata				1 ☐ Yes 27 No
	ath with the 23a or 28 ust be no	al Dire	10e. Street and Number 5720 Ripley P	ark Drive		10f. Zip Code 2 0	646	109	g. Citizen of What Co USA	ountry?
30	be filed within 72 hours after deeth with the Maryland tal Hygiene. d other than "natural", or iteme 23a or 28a-f show event. The Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  X □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:	l l	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
315-0036	72 hou natura Ical E	ted	15. Decedent's Ed (Specify only highest gra	ucation	16a. Dece	dent's Usual Occupa	ition	16	ib. Kind of Business/	
2	vithin 7 ne. hen "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,	)		Federal	Court
7 0	filed Hygi ther ant. I		17. Father's Name (First, Middle, Last)			Carpente		e (First, Middle, Ma		GOVE.
land		To Be	Carlton Bramel	1			_	Brame1	-	
nar)	2 should and Men is marke		19a. Informant's Name/Relationship (7	**					City or Town, State, 2	
e e	ges 1 and 2 should it of Health and Mer if item 27 is marke or other treumatic		David Bramel1/ 20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of			lata, MD	
Baitimore,	permit. Pages Department of I importent: If it any injury or o		1 ØBurial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Tri	nity	matory or other place Memoria	1 8/19/	06 Wa	ldorf,Ma	ryland
g	Depa Impo any i		21. Signature of Funeral Service Licen	chals -	K) -	P.O. BOX	567,LA	PLATA,	HOME,P. MD. 2064	
	25 W		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	plications that caused the death					t,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a Due to (or as a con leq	uence of	eal	Corc	el		
	Examiner		Sequentially list conditions	b						
	pel tist	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	uence of):					
'n	eath certificate be executed attending physicien and for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):					
<b>58/60</b> ,	ate be hysicie ihe bur	edical	(	d						
õ X	certifica ding pl		IF FEMALE:	23c. If yes, outcome of pregna	nev				2010	
.O. B0	the death cert y the attendin iched for use	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year
cords, P	w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	inderlying cause give	on in Part I.		cco use contribute to	o the cause of death?
L	has has	Completed						24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
VItal	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Magnitul:		0.11		h (Check only one)		
0	Phys this ral di	1: To	1 Yes No	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpaties 28b. Time o		4   Nursing no	me Residen	ce 6 □Other (Specinium occurred	cify)
0	Attending F or death. actor: After by the funer	atlor	1 Natural 5 Pending investigation	(Month, Day Year)	Injury	of 28c. Injury Work M 1 🗀	? (es 2 □ No		,,	
DIVISION	7 9 7 C	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	To the Hospitel of within 24 hours af To the Funeral D completely filled in	Medical (	29a. Certifier Certifying Ph (Check only one) Medical Exem	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deat tion and/or in	th occurred at the tim evestigation, in my op	e, date and place, pinion, death occur	and due to the cau red at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the composition of the compos	Σ	29b. Signature and title of certifier	4 Hate	~	29c. License	number	296	Date signed (Monti	h, Day, Year)
1	BIB		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print) EP	1-12	M	106	46
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 1 6	32. Reflistrar's Signa	ture	Josefe				

			1 - For State Registrar  1. Decedent's Name (First, Middle, Last)	State of Mar			of Health a			ene g. No 2	006	271	+ 1 7
	Physici		CHARLES. BAT	NES					Month  Augus T	Day	Year 2-06	3. Time or	РМ
	/Medic Examin		4a. Facility Name (If not institution, give so			_	vn, or Location of	f Death			inty of Death		
	- Funeral		Social Security Number 6. Sex	7. Age (	In yrs. last birthday)	If Under 1 Y			B. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State o	or Foreign
	Director		213-52-0909 1X	M 2 F	56 Yrs.	No. III S	1100.3		JULY 5,	1950	NORT	H CARO	LINA
	yland yland		10a. State 10b. County	1	0c. City, Town or Lo	cation					1	0d. Inside Ci	ity Limits
	Ba-1 et	ctor	MARYLAND HARFOR	D .	/AH	RE DE	GRACE					1X Yes	2 No
	or 2	Directo	10e. Street and Number 569 GTRARD STRE	ETT		10f. Zip Co	<sup>de</sup> 21078		10	g. Citizen	of What Cour USA	itry?	
	death ms 23	Funeral		2. Was Decedent Ev	er in U.S. 13.		of Hispanic Orig Cuban, Mexican,	in? (Spec	ify Yes or No-		Race · Americ		
36	72 hours after death with the Maryland naturel; or Items 23e or 28e-f ehow deal Examinations to notified at	by Fui	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give			No Specify:	, ruello n	ican, etc.)		Black, White, BLA		
5-0036	turel'		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates:	16a. Dece	dent's Usual O	ccupation		11		f Business/Inc		
215	within 72 ene. then "ne he Medir	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work d DO NOT use re	lone during most etired)	of working	9			,	
12121	filed withi Hygiene. Ither then		10 17. Father's Name (First, Middle, Last)		E	LECTRI		r'a Namo	(First, Middle, M.		LITY P	ROVIDE	R
Maryland	d be fi	o Be	JAKE BAINES							alderi Suli	name)		
ary	2 should be f and Mental h is marked of eumatic ever	2	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (St	reet and Number		ARNES Route Number,	City or To	wn, State, Zip	Code)	
	5 € Z = Z		CHRISTOPHER S. BAI	NES / BROI			D STREET						
Baltimore,			20a. Method of Disposition  1    Burial 2 □ Cremation 3 □ Re	moval from State	20b. Place of Dispo cemetery, crer BERKLEY	natory or other	r place)	8/19			on - City or To		
iţi	그는 분류		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	0			ddress of Facility	_ ·	700	DAR	LINGIO	N, MD	
1	permi		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.	ne death. Do not ent			FUNE TREE cardiac or	RAL HOME T <u>HAVRI</u> respiratory arres	E, P.		MD 21 Approximat Interval Bet Onset and I	ween Death
8760,	Medical Examiner  bhysician and  the burial-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Pos F OD:	consequence of):  STRUCTIV  consequence of):  consequence of):		MHONE	٩			7	Two we	eks
P.O. Box 68	The law requires that the death certificate be executed tee has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	Ectopic pregn Other (specif					Date of delive Month		Year
	ires that signed b d be deta	by Pl	Part II. Other significant conditions con-	inbuting to death but	not resulting in the u	nderlying caus	e given in Part I.				contribute to th		
ord	w require been si should I	ted	CHRONIC OBSTRUCT	IVE PULM	UNARY A	ISEAS	E		1 Ves			ably 4 🗀	
al Records,		Completed			144				24a. Was an autopsy perform	ed? No	b. Were auto prior to con death? 1 \(\sum \text{Yes}\)		available ause of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	2 □ ER/Outpatier	nt 3 DOA			(Check only one e 5 ☐ Resider		Other (Specifi	v)	
ō	ding Phys h. After this funeral di	on: To	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	28b. Time o	f 28c.	Injury at Work?	28	Bd. Describe how			<u>''</u>	
Division	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, farm, str (Specify)	M reet, factory, of	1 Yes 2 N		Bf. Location (Stre City or Town,		umber or Rura	i Route Num	iber,
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	(Check only one)	ician: To the best of er: On the basis of e and manner state	xamination and/or in	vestigation, in	he time, date and my opinion, deat	placa, ar th occurred	nd dua to the ead d at the time, dat	se(s) and te and plac	manner as el ce, and due to	aled the cause(s	;)
	To th within To th comp	Me	29b. Signature and title of certifier				cense number		29	d. Date sig	gned (Month,	Day, Year)	
				1.0.			(E3000	•		44 64	15T, 13	, Z 00	6
	4		30. Name and address of person who co				TH HA	1200	ER, BA	L 17110	RE, HD	, 212	25
-	Sta Regist		31. Date filed (Month, Day, Year) AUG 1 6 200	32. Degistrar		rester					-		

		- State Registrar	213topel Manylan	0 <b>4859</b> Ce	rtificate of	Death		Reg. NC U	06 27418
Physic /Med		1. Decedent's Name (First, Middle, Last)  Janet Marie Von	Bargen				2. Date of De. Month AUGUS 7	Day	Year 3. Time of Death
Exami	ner	4a. Facility Name (If not institution, give Doctors Community	Hospital		Lanhar				of Death Ce George's
Funera Director		5. Social Security Number 6. Sec 403-60-4278	7. Age (In yrs. 6.		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		1944 1944	9. Birthplace (State or Foreign Country) Kentucky
Maryland show	tor	10a. State 10b. County Maryland Prince G		y, Town or Lo					10d. Inside City Limits 1 XYes 2 No
with the	I Direct	10e. Street and Number 8801 63rd Avenue			10f. Zip Code 20740			10g. Citizen of V United	
be filed within 72 hours after death with the Maryland tal Hygiene.  d other than "naturs!, or items 23s or 28s-f show event, the Madical Examination must be invitilled at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No 1f Yes, Give Year or Dates:	'	Was Decedent of H	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No nto Rican, etc.)	- 14. Rac Blac Specify	e - American Indian, sk, White, etc. .: White
od within 72 hours at giene. er than "natursi", or	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0.12) 12	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired tary	during most of we	orking		usiness/Industry George's County S
0 5 5 c	To Be	17. Father's Name (First, Middle, Last) Charles	Caḥi	11		18. Mother's Na Christ	ine (First, Middle, ine	Maiden Surnam	Long
nd 2 lith a 27 is	1	19a. Informant's Name/Relationship (Ty. Kenneth P. Von Bar	gen -husband	19b. Mailir 8801	ig Address <i>(Street</i> 63rd Aver	and Number or Fi nue Berw	<sup>Rural Route Numbe yn Height</sup>	er, City or Town, cs, Mary	State, Zip Code) Land 20740
Definition of the partial of the paper and paper and paper and the paper and the paper and paper		20a. Method of Disposition 1	emoval from State	emetery, cren	sition (Name of natory or other place nal Mem.		Date 15/2006		City or Town, State  Maryland
permit. Pages Depertment of important: if its any injury or o		21. Signature of Funeral Service License	Bogward	- De 22	Name and Addre	ss of Facility Borgward or Mill	dt Funera Road Belt	al Home,	PA Maryland 20705
certificate be executed  Take as the burial-transit	dical Examiner	disease or condition resulting in dealh)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to	rence of):	en si	01	Arr	7	
the death certifi y the attending ched for use as	hysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	- 500		23d. Date Mor	e of delivery nth Day Year
requires that een signed b	by P	Part II. Other significant conditions con	tributing to death but not resu	lling in the ur	derlying cause give	en in Part I.			ibute to the cause of death?  3 Probably 4 Miknown
The larate has	e Completed	25. Was case referred to medical						med? d	Vere autopsy findings available trior to completion of cause of leath?
. × × ₽	To B	examiner?	ospital:	A/Outpatien	3 DOA Oth		ath <i>Check only or</i> Home 5 ☐ Resid		er (Specify)
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	/ at k? Yes 2 □ No		ow injury occurre	
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Atter completely filled in by the fune.	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (S City or Tow		er or Rural Route Number,
the Hosp in 24 hou the Funei pletely fil	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examinate)	ician: To the best of my know lef: On the basis of examination and manner stated.	vledge, death ion and/or inv	occurred at the tin estigation, in my of	ne, date and place pinion, death occ	e, and due to the durred at the time, o	ause(s) and mar date and place, a	nner as stated. and due to the cause(s)
To To	×	29b. Signature and title of certifier	)		29c, License		82	29d. Date signed	(Month, Day, Year) 12 -200-6
10		30. Name and address of person who co Cecil Donald Georg			Print)				
St Regist	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signat	ure do	ule				

Physici	an	Registrar  1. Decedent's Name (First, Middle, Last)  CLARENCE	W.	BRANI	<i>rtificate o</i> SON		Reg. I 2. Date of Death Month Aug	å, 2ŏ°6	3. Time of Death 5 10:09A M
/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	, or Location of Death		4c. County of Dea	th
		Suburban Hospi	tal			nesda		Montgor	
Funeral		<ol> <li>Social Security Number 6. Set</li> </ol>	7. Age (I	n yrs. last birthday 89 Yrs.	Months Day	ar II Under 24 Hrs.	8. Date of Birth (Month, Day, Yea Dec. 12, 1	9. Bir	thplace (State or Foreig
Director	1	212-20-1211 Usual Residence of Decedent		0.9 113.		1	Jec. 12,1	916	Maryland
yland		10a. State 10b. County	10	Dc. City, Town or L	ocation				10d. Inside City Limits
Man	ţ	MD Montgom	nery	Po	tomac				1 ☐ Sres 2 ☐ No
or 28	Director	10e. Street and Number			10f. Zip Code	•	10g.	Citizen of What C	ountry?
72 hours after death with the Maryland Instural', or tlems 23a or 28a-f show dical Examinal must be notified at	rail	7833 Scotland	Drive			20854		U.S.A.	
er de Items	Funerai	11. Maria Status	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No	or in U.S. 13.	Was Decedent of If Yes, specify Cu	f Hispanic Origin? (Speuban, Mexican, Puerto F	city Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
irs aft	by	1 Never Married 2 Married 3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X N	lo Specify:		Specify: B	lack
72 hours "natural", dical Exp	ted	15. Decedent's Edu		16a. Dece	dent's Usual Occ	upation	16b	. Kind of Business	/Industry
Media 7	pie	(Specify only highest grad	College (1-4or 5+)			ne during most of workir ired)			
filed within Hygiane. Ither than "	Completed	7th		Ti	re Repa			Tire Co	) •
2 should be filed within and Mental Hygiane. Ie marked other than eumatic event, tre M	Be	17. Father's Name (First, Middle, Last)  Lawrence Bran	ni son			18. Mother's Name Gertri	(First, Middle, Maid	nknown	
should be ind Mental marked o umatic eve	2			105 14-1	Address (Ohro	net and Number or Rura			Tin Codel
ii. Peges I end 2 should be filed within 72 ho entment of Heelin and Mental Hygiane. rtant: If Item 27 ie marked other than "natuu njury or other treumatic event, Ita Madical		19a. Informant's Name/Relationship (T)				es St Cli			Zip Code)
1 end Heelt em 2		Deborah A. Byr  20a. Method of Disposition		20b. Place of Disc	osition (Name of	. D		Location - City or	Town, State
Peges nent of nnt: If it		1 ⊠Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	St. Pa	matory or other p ul Cem	8/15	/06 P	oolesv	ille, MD
permit. Peges 1 end 2 Department of Heelth a Important: If Item 27 is any injury or other tre		21. Signature of Funeral Service Licens	ee /			dress of Facility Sno			
permit. Departr Imports any inj pace.	4	- CO000 M	of XI			Washingto			
		23a. Part1. Enter the disease, of complete	ications that caused the					ONVILL	Approximate Interval Between
hysician		shock, or heart failure. List only o Immediate Cause (Final		0 . IAAO					Onset and Death
/Medical	-	disease or condition resulting in death)	Due to (or as a c						30
Examiner		Sequentially list conditions	$\mathcal{R}$	ecuren	+ Hea	dand N	eck Ca	ncer	Amo
D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated quents	Due to (or as a c	onsequence of):					
ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):					
be ex ician burial	cal E		Due to (01 as a 0	onsoquoneo or,					
phys the		_	1						
es that the death certifica igned by the ettending ph be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of de	olivery
death e etter	ciar	in the past 12 months?	1□Live birth 2 ( 4□Pregnant at tim		∐Ectopic pregnai ☐ Other <i>(specify)</i>			Month	Day Year
t the o	hys	9 Unknown	9□ Unknown				-		
s tha	by P	Part II. Other significant conditions co	ntributing to death but r	not resulting in the	underlying cause	given in Part I.	23e. Did tobacc	co use contribute t	to the cause of death?
w require been sig should to	Ped						1 Tes	2 □ No 3 □	robably 4 Unknow
aw requ	Completed						24a. Was an autopsy	24b. Were a	utopsy findings avaital completion of cause of
The I	E						performed	? death?	1
ien: artifice ctor. p	Be	25. Was case referred to medical examiner?				26. Place of Death	Check only one		
hysic his ce I dire	10	1 ☐ Yes 2 No	lospital:	2 ER/Outpatie	HIL 3LI DOA		ne 5 Residence	6 □Other (Spe	ecify)
ng P Iter t inera		27. Mann of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	'ear) 28b. Time Injury		Vork?	28d. Describe how in	ntury occurred	
	Certification;	2 Accident investigation 3 Suicide 6 Could not be	20 21 (1-1)	445		☐Yes 2☐No	206 Leastine (Ctean)	and Mumber of C	Description of the second
tendil leath. lor: A the fu	E	4 Homicide determined	28e. Ptace of Injury building, etc. (	'- At nome, farm, s 'Specify)	treet, factory, offic	20	28f. Location (Street City or Town, St		turat Houte Number,
or Attending Physicien: The law requires that the death certifics ther death.  Jirector: After this certificete hes been signed by the ettending ph in by the tuneral director, page 2 should be detached for use as it in by the tuneral director.			eicien: To the hest of r	ny knowledge dea	th occurred at the	time date and place a	and due to the cause	a(s) and manner a	s stated
pitel or Attendi ous efter death. erel Director: A filled in by the fu		292 Contifier VC Contituing Phy		camination and/or i		y opinion, death occurre			
Hospitel or Attendi 24 hours efter death. Funerel Director: A stely filled in by the fu		29a. Certifier Certifying Phy (Check only one)	and manner state	d.					
to the Hospitel or Attendivithin 24 hours efter death.  • the Funerel Director: A completely filled in by the fu	Medical Ce	(Check only 2 Medical Exam		d.	29c. Lice	ense number	29d.	Date signed (Mon	ith, Day, Year)
To the Hospitel or Attending Physicien: The law within 24 hours effer death.  To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2		(Check only 2 Medical Exam		u ROL	29c. Lice	ense number )54-27.7	29d.	Date signed (Mon	oth, Day, Year)
To the Hospitel or Attendi within 24 hours effer death. To the Funerel Director: A completely filled in by the tr		(Check only 2 Medical Exam	and manner states	vel	ME	ense number )54722	29d.	Date signed (Mon	ith, Day, Year)

		For State of Man	•	rtment of Hetificate of L		lental Hyg	ene 9. <b>2</b> 0 0	)6	27420		
		Decedent's Name (First, Middle, Last)				2. Date of Deat	n		3. Time of Death		
Physic	an	Pearl B. Brandon				Month August	9, 200	Year )6	4:45 A M		
/Medi		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	1148454	4c. County				
Examir	ner	Manor Care Health -Bethesda		Bethesd			Monte	omer	V		
			In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,			ace (State or Foreign try)		
Funeral Director		578-07-1931 1□M 2図F 10	4 Yrs.	Months Days	Hours Min.	July 6,	1902	Wash	D.C.		
		Usual Residence of Decedent				our, o,					
/land		10a. State 10b. County 1	0c. City, Town or Loc	cation				10	Od. Inside City Limits		
Many -f sh Tied	to	Maryland Montgomery	Bethesda						1X Yes 2 No		
r 288	Director	10e. Street and Number		10f. Zip Code	-	11	g. Citizen of V	Vhat Coun	try?		
3a o	D E	6530 Democracy Blvd.		20817			United	State	es		
death ms 2	Funeral	11. Marital Status 12. Was Decedent Every Armed Forces?	er in U.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No-		e - Americ			
after or Ite	F	1 Never Married 2 Married 1 Yes, Give		Yes 20 No	Specify:	riicari, cic.,			_		
ours a	by	3X Widowed 4 ☐ Divorced Year or Dates:		□ res 🍇 INO	Зреспу.		Specily	· Blac	i K		
natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupa kind of work done d OO NOT use retired,	ation Juring most of work	ing	16b. Kind of Bu	usiness/Ind	lustry		
Fig.	pje	Elementary/Secondary (0-12) College (1-4or 5+)	1		)			_			
od will	No.	12	Home	emaker			Domes				
be filed within 72 hours after death with the Maryland half Hygiene.  Idea Hygiene.  In the maturel, or terms 23a or 28a-f show event, I'm Medical Evaninar must be notified at	Be (	17. Father's Name (First, Middle, Last)			18. Mother's Name			ne)			
Vent Went Went wrkec	Į.	Samuel Shelton			Rebecca	Robinso	n				
2 should and Mer Is marke		19a. Informant's Name/Relationship (Type, Print)		g Address (Street a							
and 2 and 2 ealth m 27		Yvonne B. Scott (daughte		Parker A					0902		
D - 1 5 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place	θ)	Date	20c. Location -	City or To	wn, State		
Definition Pages Department of I mportant: If it in in y injury or o once.	1	'4 □ Donation 5 □ Other (Specify)	Pleasant	Valley	8/15	5/06 A	nnanda1	e, Vi	rginia		
permit. Departmine on your permit. Imports any inju		21. Signatur of Juneral Service Licensee	22	. Name and Addres	ss of FacilityMcGu	ire Fun	eral Se	rvice	2		
		Inolre Thompso	74	400 Georg	ia Ave. N	N.W., Wa	shingto	n, D.	C. 20012		
		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	ne death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between		
Physician		Immediate Cause (Final	1 -	lure					Onset and Death		
/Medical		disease or condition resulting in death)  Due to (or as a condition)		· · ·	•				30043		
Examiner		HUT	Due to (or as a consequence or):								
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):	. , , , ,					2		
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	2				ofc.				
exec n an ial-tr	Exa		consequence of):								
Ords, F.C. BOX 60/00, requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit	dicai	d									
ificat g phy as th	edi										
GOIGS, F.O. BOX O wrequires that the death certific been signed by the attending I should be detached for use as	ician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of 1 ☐ Live birth 2		Ectopic pregnancy				te of delive			
death death	icia	in the past 12 months?  4 Pregnant at tir		Other (specify)			Mo	nth	Day Year		
oy the ache	Physi	9 Unknown									
that ned to	by P	Part II. Other significant conditions contributing to death but		nderlying cause give	en in Part I.	23e. Did tol	acco use cont	ribute to th	e cause of death?		
tuires n sign	D D	ADVANCED AG	E.			1 □ Ye	s 2 No	3 ☐ Prob	ably 4 (Winknown		
ecords, law requires t as been signe	Completed					24a. Was a	n 24b.	Were auto	osy findings available		
The law ate has b page 2 st	m					autops	ned?	death?	npletion of cause of		
n: Ti	ပိ	25. Was case referred to medical			26. Place of Deat		•	1 🗌 Yes	2 No		
OT VICAL REC Physicien: The law this certificate has b ral director, page 2 sl	o Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatien	Oth	00	me 5 Reside	-	or /Snacifi	4		
Phys	1	27. Manner Death 28a. Date of Injury	28b. Time of			28d. Describe ho			7		
ding Afte fune	tion	1 ☐ Natural 5 ☐ Pending (Month, Day 1 2 ☐ Accident investigation	Year) Injury		k? Yes 2 □No						
ISI Witten deat deat ctor: y the	fica	2 7 700 00 11 11 11 11	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (St	reet and Numb	er or Rura	l Route Number,		
LIVISION I or Attending after death. Director: Afte	Certification:	4 Homicide determined building, etc.	(Specify)			City or Town	n, State)				
DIVISION OF To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di		29a. Certifier 1 Certifying Physician: To the best of									
24 h Fur etely	Medical	(Check only 2 Medical Examiner: On the basis of e		vestigation, in my o	pinion, death occur	red at the time, d	ate and place,	and due to	the cause(s)		
o the omple	Me	29b. Signature and title of certifier		29c. License	e number	2	9d. Date signe	d (Month,	Day, Year)		
F 3 F ŏ		halfoo histo		DR	1319		8-9	-0	C		
4		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type		/		- [				
1			Wisconsin		.#305. Be	ethesda.	MD 20	814			
2	tate				,	,					
Regis		31. Date filed (Month, Day, Year)  AUG 1 5 2006  32. egistrar	's Signature	nace							

			For  State Registrar	State of Maryland		artment of H			giene Reg. No. 2 A A	6 271.21
¥*aè	Physicia	an_	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day Yea	3. Time of Death 6:30 P. M
	/Medic Examin	al	GARY MTCHAEL CLA  4a. Facility Name (If not institution, give str  LAUREL REGIONAL HO	eet and number)		4b. City, Town, or LAUREL			4c. County of De	ath
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bir (Month, Da 04-29-	v. Year)	inthplace (State or Foreign Country) Sh., D.C.
	he Maryland 18a-1 ahow ottilled at	Director	Usual Residence of Decedent           10a. State         10b. County           Maryland         Montgomer           10e. Street and Number		, Town or Lo	Spring  10f. Zip Code			10g. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or 2		3001 Calverton Bou	levard		2090	16		U.S.A.	304,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral		2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin an, Mexican, P Specify:	? (Specify Yes or No Puerto Rican, etc.)	14. Race - A Black, W Specify: W	
21215-0036	filed within 72 hou Hygiene. ther then "nature int, the Medical E	Completed	15. Decedent's Education of the state of the	ation completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired ract work	during most of d)	f working	16b. Kind of Busine Private I	
73	2 should be filed withir and Mental Hygiene. Is marked other than sumatic avent. Lie M	To Be Co	17. Father's Name (First, Middle, Last)  Clarence Edward Cla	rk			18. Mother's	Name (First, Middle ia Makin	, Maiden Surname)	
Mary	d 2 shouth and N		19a. Informant's Name/Relationship (Type Pansy Stancil-Diaz			•			e, MD 20737	a, Zip Code)
	ages 1 an nt of Heal t: if item? f or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	lace of Dispo emetery, cre	osition (Name of matory or other place	ce)	Date 3-11-2006	20c. Location - City Suitland,	
Baltimore,	permit. Pages 1 and 2 Department of Health s important: if item 27 is any injury or other tra once.		21. Signature of Funeral Service Licensee  May E Hedgy		2:	2. Name and Addre	ss of Facility		. Suitland	
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death cause on each line.  Gastroesopha				irdiac or respiratory a	irrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in doutiny	Due to (or as a consequence Gastroesopha Due to (or as a consequence consequen	uence of):					
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events	Achalasia wi	th Bai					
8760,	certificate be executed iding physicien and ise as the burial-transit	edical Ex	resulting in death) Last	Mediastinal		nfraclavi	cular			
Box 6	death e atter	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of c	il death 3	□Ectopic pregnanc □ Other (specify)	у		23d. Date of Month	delivery Day Year
rds, P.O.	equires that the desert sen signed by the tould be detached	ed by Ph	Part II. Other significant conditions conditions Mental Retar		ulting in the	underlying cause gi	ven in Part I.			e to the cause of death? ]Probably 4 🙀Unknown
Reco	e law r has be je 2 sh	Completed by						24a. Wa. auto peri 1 🗆 Yes	opsy prior ormed? deat	a autopsy findings available to completion of cause of n? fes 2 \square No
Vita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		· · Oti	hac	of Death (Check only		
Division of Vital Records,	ding Phys n. After this funeral di	tion: To	1 ☐ Yes 2 ☐ No  27. Manner of Death  12 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Inju	7 14013	28d. Describe	sidence 6 Other (S how injury occurred	Бресіту)
Divisi	in Piere	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, s	treet, factory, office			(Street and Number o own, State)	r Rural Route Number,
	a Hospitai 124 hours a Eunerai I letely filled	edicai (	25a. Centifier (Check only one) Certifying Physical Examin	lclan: To the best of my knower: On the basis of examination and manner stated.	owledge das ation and/or i	ith conumed at the ti nvestigation, in my	ime, date and opinion, death	place, and due to the coccurred at the time	, date and place, and	r as stated due to the cause(s)
	To the To the To the Complex c	Me	29b. Signature and title of certifier	0 =			se number		29d. Date signed (M	lonth, Day, Year)
				majored on the districts districts	m 22a) /Tue-	DO13	687		08-09-200	)6
2			30. Name and address of person who co JOSELITO MAGDAY,		Roby	Avenue B	eltsvi	lle, Maryl	and 2070	; 
	St Regis	ate	31. Date filed (Month, Day, Year)  AUG 1 5 2006	32. Registrar's Sign	ature	de.				

			For Stata Registrar	State of Maryla	ind / Dep <i>Ce</i>	artment of H <i>rtificate of</i>	lealth and Death		iene∠UUb og.No.	27422
	Di vi		1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h Day Year	3. Time of Death
	Physici /Medic		John B	Case				August	15 th 200	6 1:42 pm
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Deat	h	4c. County of Dea	th
			University of Mary			Ba	Itimon	0_		
	Funeral Director		217-74-0704	M 2□F 7. Age (In yr	s. last birthday,  S Yrs.	Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, SEPT 1	Year)	thplace (State or Foreign ountry) ASH DC
	and *		Usuat Residence of Decedent  10a. State 10b. County	10c. (	City, Town or L	ocation				10d. Inside City Limits
	Aaryl • • • • •	ច	MD FREDER		MONRO					1 ☐ Yes 2 🕱 No
	280-	ect	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	with Se or		3001 BURNS CT.			2177	n		US	•
	Jeeth Tre 2%	era		2. Was Decedent Ever in	U.S. 13.	Was Decedent of H	Hispanic Origin? (S	pecify Yes or No-	14. Race - Am	
21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at Appres.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 💢 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		If Yes, specify Cubin	an, Mexican, Puer Specify:	o Rican, etc.)	Black, Whi	
Š	2 hor	ted	15. Decedent's Educ		16a. Dece	dent's Usual Occur	pation		16b. Kind of Business	/industry
215	hin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	/i/e.	kind of work done DO NOT use retire	d)	rking		_
	or th	5	12		TRU	JCK DRIV	ER		TRUCKIN	G
Maryland	be file	Be	17. Father's Name (First, Middle, Last) BERNARD ELLSWOR!	TH CASE				me <i>(First, Middl</i> e, A 'HARLのでで	Maiden Sumame) E EASTON	
Ž	d Mer narka natic	ဥ			10h Maili	4 44 /644				T- 0-4-1
Ma	d 2 s th an t7 ie r traur		19a. Informant's Name/Relationship (Type M. CHARLOTTE CA	-					City or Town, State, BEACH,	
	Heal Heal tem 2		20a. Method of Disposition	20b	. Place of Disp	osition (Name of		Date	20c. Location - City or	
ομ	ages ant of it: If i		1 ☐ Burial 2 1 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State F	REDER	matory or other plac CK	CO LAUG	. 17 .06	FREDERIC	K, MD
Baltimore,	ertme ortan injur		21. Signature of Funeral Service License	e	CREMAI			To State of the st		
B	Depermine Company is any is				1	2. Name and Addre HILTON F O. BOX	UNERAL 86, BA	HOME RNESVIL	LE, MD	20838
ľ			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the de	ath. Do not en					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition							Onset and Death
	/Medical		resulting in death)	Due to (or as a cons	> equence of):					
	Examiner		Sequentially list conditions, b	Superio Due to lo as a cons	- Me	sentem	throm	ocic		July 2006
	ס ∺	Examiner	n any, leading to immediate cause. Enter Underlying	Due to (o as a cons	equence of):					
	icate be executed physicien and s the burial-transit	cam	Cause (Disease or injury that initiated events resulting in death) Last	D						
8760,	cien a	Ē	issuing in doubly basis	Due to (or as a cons	equence or);					
87	physic the t	dicai								
9 ×	ding	/Me	IF FEMALE:	3c. If yes, outcome of preg	nancy				004 Private	
å	atten for u	clan	in the past 12 months?	1☐Live birth 2☐Fe 4☐Pregnant at time of	etal death 3	☐Ectopic pregnancy ☐ Other (specify)	4		23d. Date of de Month	Day Year
o	y the d	ysle	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	dou of					
<b>a</b> .	Attending Physicien: The law requires that the death certif r death. sroor: After this certificete has been signed by the attending by the funeral director, page 2 should be detached for use a	by Physician/Me	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	acco use contribute t	the cause of death?
ds	quires n sigr		Palmonary	Embol	ism			1 □ Ye	s 2 12 No 3 □ P	robably 4 Unknown
Ö	w require s been sig	lete	Pulmonary Liver Cir	who acic	•			24a. Was a	n 24b. Were a	utopsy findings available
æ	The la	Completed		100317				autops perform	ned? _ death?	utopsy findings available completion of cause of
ta	en: Tiffice	0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2		3 2 □ No
$\geq$	ysici is cer direc	0 0	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	000		ince 6 □Other (Spe	ocify)
0	ng Ph ter th	T:U	27. Manner of Death  1 ☑Naturat 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injur		T	w injury occurred	
<u>ō</u>	andir. oath. or: Af	atlc	2 Accident investigation		,,		Yes 2 □No			
Division of Vital Records, P.O. Box	i or Attending Physicien: The lavefier death. Diractor: After this certificete has in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st	reet, factory, office		28f. Location (St. City or Town	reet and Number or R , State)	ural Route Number,
	To the Hospital or Attentwithin 24 hours effer deatl To the Funeral Director: completely filled in by the		an and a second				11 20 11 11			
	Hosi 24 ho Fund Italy f	edical	29a. Certifier (Cineck only one)  1 Certifying Phys 2 Medical Examin	ician: To the best of my k er: On the basis of exami and manner stated.	nowledge, deal nation and/or in	h occurred at the tire ivestigation, in my control in the control	me, date and place pinion, death occu	), and due to the ca irred at the time, da	tuse(s) and manner a ate and place, and du	s stated. e to the cause(s)
	o the o the orthe	Mec	29b. Signature and title of certifier	and manifer stated.		29c. Licens	e number	25	9d. Date signed (Mon	h, Day, Year)
	⊢≯⊢ŏ		An Dol	1 MD		017	740	1	AUGUST 19	
	(-	ĺ	30. Name and address of person who con	noteted cause of death (it	em 23a) (Type		, ,,			
	5			22 SOUTH			BALTIM	ORE , MI	2/2.01	
	Sta	te	31. Date filed (Month, Day, Year)	32. Rebistrar's Sig	nature		,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	Registr		AUG 1 7 20	106	L	/				

State of Maryland / Department of Health and Mental Hygiene 006 27423 For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Doris Cates **Physician** August 2006 12:41AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 7048 Oak Glen Dr. Hughesville Charles If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🖫 F Director 579-42-1272 1935 Washington, DC Feb. Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits r than "naturel", or Items 23a or 28e-f shov the Medical Examinational Lectualities at 1 ☐ Yes 257 No Director Maryland Charles Hughesville 10g, Citizen of What Country? 10e, Street and Number 10f. Zip Code 7048 Oak Glen Drive 20637 USA Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 ₩ Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Importent: if Item 27 is marked other tha any injury or other treumatic event, Italy once. Secretary 12 Hughes Aircraft 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John White Minnie Chaney ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1220 Tanley Road, Silver Spring, Maryland 20904 George Hartley/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Brinsfield-Echols Cr. 8/16/2006 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. D Jan lon 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jisease or it jury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy o Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 Tes 2 No 3 Probably 4 Nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 25 1 ☐ Yes 2 ☐ No Physicien: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 sesidence 6 Other (Specify) 1 🗌 Yes Certification: To this 28d. Discribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Deal After Hospitel or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide within 24 hours a To the Funerel I 11 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number our address of person who completed cause of death (Item 23a) (Type, Print) 0 distrar's Signature Day, Year 31. Date filed (Month 32. R State AUG 1 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygien 2006 27424 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 11:10 A M Mary Davis Crowell 12 2006 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Kent Chester River Hospital Center Chestertown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 01/27/1923) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖎 Director 83 Ohio 283-16-5572 Usual Residence of Decedent the Maryland 10a State 10c City Town or Location 10b County 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 501 E. Campus Avenue 21620 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) illed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 1 No Specify: þ 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygiens Important: If Itam 27 is marked other tha any injury or other traumatic event. Secretary Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Charles Joseph Davis Minnie Eschmever 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13701 Heatherstone Drive,Bowie,Maryland 20720 Kathleen C. Donohue/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ \*Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Kalas Crematory 4 Donation 8/15/2006 Edgewater, Maryland uneral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 alex 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mag lev /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be executed Due to (or as a consequence of) attending physicien Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day 4 Pregnant at time of death 5 ☐ Other (specify) the Division of Vital Records, P.O. detached à Part II. Other significant conditions contributing to death by not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 90 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 Yes 2 No Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending death. 1 Yes 2 No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funerel Direct 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca (Check only one) 29c. License number 006030 1 29b. Signature and title of certifie Path (Hom 23a) (Type College Pen Paux No 31. Date filed (Month, Day, Year) istrar's Signature State AUG 1 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 27425 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2006 0450 M 4a. Facility Name (If not institution, give street and number) 12 August /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 4, 1959 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Vietnam 1∰M 2□F 46 Yrs. 219-39-0543 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in then "natural", or Iteme 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Germantown Maryland Montgomery Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 United States 13800 Bailiwick Terrace Funeral death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Asian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Assembler Electronics 12 Pages 1 and 2 should be filed w treent of Health and Mental Hygientant: If Item 27 is marked other ti lury or other treumatic event, IL. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) My Thi Nguyen Chung Ngoc Dao 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13800 Bailiwick Terrace, Germantown, MD 20874 Tien Duy Dao/ Brother Baltimore, 20c. Location - City or Town, State Silver Spring, 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) Gate of Heaven August 15, 2006 1 XBurial 2 Cremation 3 Removal from State Department o Important: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Maryland 22. Name and Address of Facility DeVol Funeral Home, 21 Signature of Funeral Service Licenses 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatiz 46 months Non Small Cell Lung /Medical Due to (or as a consequence of): **Examiner** Superior Vena
Due to (or as a consequence of): Vena Cava Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as i IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No jo 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown as been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate har funeral director, page performed? 2□ No 1 Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 1💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 5 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 5 (8)Bauren MD060335 MD August 12, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #327 Olacy Prince Philip MD 20832 Bonnen 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 1 5 2006 Registrar

			For State Registrar	State of Mar	ryland / C	epartmen Certificat	t of Healt e of Dea	th and M	lental Hy	giene Reg. No.	2006	274	26
	Physicia /Medic	al	Decedent's Name (First, Middle, L     Robert Depser  4a. Facility Name (If not institution, gi	ast)			Town, or Locat		2. Date of De Month August	Day	Year	3. Time of De 3:35	eath A <sup>M</sup>
	Examin Funeral Director	er	Bradford Oaks N	ursing Home	(In yrs. last birt		Clinton	nder 24 Hrs.	8. Date of Bir (Month, Da Feb. 24	Pr	rince Ge	eorges	Foreign
e Maryland	a-f ahow	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgom		10c. City, Towr	or Location Spring						10d. Inside City I	
rs after death with the	if Health and Mental Hygiene. Itam 27 is marked other then "netural", or Items 23e or 28e-f ahow other traumatic event, the Medical Exercitor must be notified at	by Funeral Directo	10e. Street and Number  2904 Stanton Roa  11. Marital Status  1 □ Never Married 2 □ Married  3 □ XWidowed 4 □ Divorced	12. Was Decedent Ev Anned Forces? 1 ☑Yes 2 ☐ No		13. Was Decedif Yes, spec	dent of Hispanic city Cuban, Med	20910 c Origin? (Spe xican, Puerto	ecify Yes or No Rican, etc.)	)-	US  14. Race - Amer Black, White Specify:	ncan Indian,	
d within 72 hou	giene. ar then "neture . the Medical E	Completed	15. Decedent's 8 (Specify only highest g.	ducation		Decedent's Usua (Give kind of wo life. DO NOT us COUNTAN	rk done during se retired)	most of worki	ing		Account		
ylarid ould be tile	Mental Hy varkad oth vatic evant	To Be (	17. Father's Name (First, Middle, Lasunavailable					unavai					
1 and 2 sh	Health and tam 27 is m other traum		19a. Informant's Name/Relationship  Lucretia Tanner -  20a. Method of Disposition		n law 1	Disposition (Nar.	den Wes	twood		Brand		MD 20613	3
Demit. Pages	Department of Health a Important: if Itam 27 is any injury or other tra		1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Service) Lice	ify)	Huntt	crematory or of Cremato  22. Name an			3035		ldorf, lashingt		
ğ ē	de la general		23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused th		ot enter the mod	e of dying, sucl	h as cardiac c	POB 15 or respiratory a	66, W		MD 2060 Approximate Interval Between	
/	nysician Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Acu	er m	yo card	in) In	nfac	ting			Onset and Dea	
		icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a condition of the cond	,								
UIVISION OF VIGI DECOLOS, F.C. BOX 60/00, the Hospital or Attending Physician: The law requires that the death certificate be executed	been signed by the attending phy should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death	3 □Ectopic pr 5 □ Other (sp				2	23d. Date of deli	very Day Yea	ar
w requires that	an signed b	۵	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying c	ause given in P	Part I.	23e. Did t		1	the cause of deal	
The law re	icete has been, page 2 sho	Completed							24a. Was auto perfo 1 Yes		24b. Were aut prior to death? 1 \(\sum \text{Yes}\)	topsy findings ava ompletion of caus 2 \(\sum \text{No}\)	ariable se of
nding Physician	within 24 hours atter death. To the Funeral Director: Atter this certilicate has completely tilled in by the funeral director, page 2	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 ONatural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient  28a. Date of Injury (Month, Day)			100	Wursing Hor	n <i>(Check only o</i> me 5 ☐ Resi 28d. Describe	dence 6	S □Other (Spec y occurred	ufy)	
DIVIS	within 24 hours atter death. To the Funeral Director: A completely tilled in by the fu	Certification:	3 Suicide 6 Could not determined	building, etc.	(Specify)				City or To	wn, State)	)	ral Route Number	r,
To the Hos	othe Function of the Function	Medical	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa  29b. Signature and title of certifier	hysician: To the best of miner: On the basis of e and manner state	xamination and	d/or investigation	at the time, dat , in my opinion, c. License numb	, death occurr	and due to the ed at the time,	date and	and manner as place, and due signed (Month	to the cause(s)	
_	, - 0		30. Name and address of person who	completed cause of dea	ith (Item 23a) (	Type, Print)	D352	206	¬ ,	Ac	igust	13, Zw	9
18	741 Sta	te ar	31. Date filed (Month, Day, Year) AUG 1 6	2008 32. Registrar	s Signature	Li Ving.	it m Ri	me b	-or	WAS	strond gr	a, vey	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 27427 1 - For State Registrar Certificate of Death Rea. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2006 **Physician** 5, AUGUST FONTENEAU 12:00PM BERNICE Ε. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONTGOMERY SILVER SPRING WOODSIDE CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan 8 , 1915 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 □ XF Tenn. Yrs. Director 236-07-0531 91 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d Inside City Limits 1 Yes 2 No Completed by Funeral Director D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20010 3128 Sherman Ave., N.W. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 St No Specify: Specify: Black Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Govt. Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Lee Ware 2 Ann E. Finley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3128 Sherman Ave., NW Wash., DC 20010 Wendy Gray / Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rock Creek Cemetery 8-11-06 \* 4 ☐ Donation 5 ☐ Other (Specify) Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Capitol Mortuary, Inc. Causes 1425 Maryland Ave., NE Wash., DC 20002 23a. Part 1. Enter the dilease or complications that/caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician CEREBROVASCULAR ACCIDENT disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ATRIL FIBILATION Sequentially list conditions Sua to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) 29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

The law requires that the death certificate be executed

Box 68760,

P.O. |

Division of Vital Records,

Physician:

or Attending

Hospital

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
Int: If item 27 is marked other than "natural; or Itams 23a or 28a-1 show

Baltimore, Maryland 21215-0036

27 is marked other than "natural", or Itams 23a or 28a-1 show traumatic event, the Medical Examinar must be notified at

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State Registrar Gilbert E.

31. Date filed (Month, Day, Year)

AUG 1

30. Name and address of person who completed cause of death (Item 3a) (Type, Print)

M.D.

32. Registrar's Signature

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5 2006

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Wash., DC 20006

St., N.W.

8-7-06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 27428 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Finn, Jr. Bart Joseph August 11, 2006 5:03 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year 1 M 2 F Hours Months Days 79 Sept. 6, 579-44-9616 1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3359 Aisquith Farm Road 21035 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

Yes 2 □ No6-1-44

Wes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 → Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 6-6-46 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer U.S. Park Police 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bart Joseph Finn, Sr. Catherine L. Hannan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 585 Riva, Maryland 21140 Beverley A. Finn (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) August 15, Maryland Veterans Cemetery Crownsville, Maryland 2006 21. Signature of Tunera Service Licensee 22. Name and Address of Facility Advent Funeral & Cremation Services M00982 42 Hudson St., Suite 110, Annapolis, MD. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Physician /Medical Immediate Cause (Final disease or condition resulting in death)

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural; or items 23a or 28a-f ehow any injury or other traumatic event. If a Maryland contract or other traumatic event.

Baltimore, Maryland 21215-0036

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed

attending physician and for use as the burial-transif within 24 hours after deat To the Funeral Director: completely filled in by

Division of Vital Records, P.O. Box 68760,

Sacual thily list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse  c. Due to (or as a conse  d.	,				
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3 Suicide 6 Could not determine		nome, farm, street, factory, o	office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route f e)	Vu <i>mber</i> ,
29a. Certifier 1 Certifying F (Check only 2 Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occurred at ation and/or investigation, in	the time, date and place my opinion, death occ	e, and due to the cause(s urred at the time, date an	s) and manner as stated. Id place, and due to the caus	se(s)

29c. License number

038328

TUBERCULOSIS

State Registrar

31. Date filed (Month, Day, Year) AUG 1 5 2006

MARY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier/



- MO MPH

PULMONARY

Due to (or as a consequence of):

29d. Date signed (Month, Day, Year)

HINDM 340

State of Maryland / Department of Health and Mental Hygien ? 1 15

		For State Registrar	State	of Man	yland / D	epartmer Certifica	nt of He te of E	ealth an Death	nd Men		en <b>2</b>	006	27429	
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			For State Registrar	State of Ma	-		rtment of He rificate of D		ental Hyg	ene 20	06	27430
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0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mendle Hygiene.  Department of Health and Mendle Hygiene.  Department of Health and Mendle Hygiene.  Brain injury or other treumatic event, the Medical Examiner must be notified at 200ce.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Toivorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 M N If Yes, Give Year or Dates:			as Decedent of Hisp Yes, specify Cuban, □ Yes 2∑ No	panic Origin? (Spe Mexican, Puerto I Specify:	cry Yes or No- Rican, etc.)		- American k, White, etc	
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ne. hen "nati	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		5+)	_	kind of wo DO NOT u	al Occupa irk done d se retired,	ition <i>Juring</i> mosi )	t of worki	ng		ind of Bus			
Hygiene. ither then out, it a Ma		17. Father's Name (First, Middle, Last)			Far	ner		18 Mothe	ır's Name	(First, Middle		lf-Em		red	
and Mental Hygiene. Is marked other then aumetic event, tre M	To Be	Ioan Filip	D : 1		100.00			Ile	ana	Carcu I	Filij	р			
7 is not traum		19a. Informant's Name/Relationship (T)								I Route Numb					
		Elena Enciu/Daugl  20a. Method of Disposition  12 Burial 2 □ Cremation 3 □ F		9	Place of Dispo cemetery, crer	nsition (Nar matory or o	me of other place	9)	C	Boons!	20c. L	ocation - C	ity or To	wn, State	
Depertment of Important: If eny Injury or pace.	1	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens		Re		2. Name ar	nd Addres	s of Facilit	y Re	/2006 st Have venue,	n F		1 Ch	apel	
hysician physician and the prinapped the prinapped the prinapped the prinapped the physician and the p	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a Arter  Due to (or a	ialsc saconseq l Fib	uence of): leroti uence of): rillat	c Car	n'ne		ar D	isease	-			15ye	
ive hes been signed by the attending physicien and bage 2 should be detached for use as the burral-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fete	I death 3	Ectopic pr						23d. Date Mont		ry Day	Year
signed b	۾	Part II. Other significant conditions col	ntnbuting to death	but not res	ulting in the u	nderlying c	ause give	n in Part I.			obacco Yes 2	use contrib	oute to th	3	death JUnkr
	Completed											pride	or to cor	osy finding nptetion o	s avail cause
0.6	Be	25. Was case referred to medical examiner?	fospital:				Othe	- 1		(Check only o					
h. After this funeral di	lon; To	27. Manner of Death  1 Natural 5 Pending	28a. Date of In (Month, D		28b. Time of Injury		28c. Injury Work	NO NO	2	ne 5 Resi				")	
within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined		njury - At ho	ome, farm, str y)					28f. Location (. City or To			r or Rura	l Route N	ımber,
within 24 hours a To the Funeral completely filled	edical	29a. Certifier 1 Certifying Phyone) 2 Medical Exami	sician: To the bes ner: On the basis and manner s	of examina	wledge, death	h occurred vestigation	at the tim	e, date an	d place, a	and due to the ed at the time,	cause(s date and	and man	ner as st nd due to	ated. the cause	∋(s)
within 2 To the complet	M	29b. Signature and title of certifier	9 Mu	al	7	290	License	number	1			te signed	. /		)

			For State Registrar	State of M	aryland	/ Depa	artment of F tificate of	lealth and Death		giene Reg. No.	2006	27432	
	Physici	1. Decedent's Name (First, Middle, Last)  Physician  Louise Augusta Criffin								ath Day	Year	3. Time of Death	
	/Medio	al	Louise Augusta Griffin				# 6° T	August		2006	8:24 P. M		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Items 23a or 28a-1 ehow any injury or other treumatic event, the Medical Executive countries at one and one of the medical Executive countries at one of the medical Executive countries at one of the medical Executive countries at one of the medical Executive countries at one of the medical Executive countries at one of the medical Executive countries at one of the medical Executive countries at the medical Executive countries	ier	4a. Facility Name (If not institution, give street and number)  Prince George's Hospital Center				4b. City, Town, or Location of Death  Cheverly			4c. County of Death Prince Georges			
						last birthday) If Under 1 Year If Ur		If Under 24 H		h		place (State or Foreign ntry)	
0		Director	577-38-1402	1□M 2KDF /	/	Yrs.	Months Days	Hours Wi	n. 1/1/29	, 1001)		yland	
			Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Town or Loc	cation					10d. Inside City Limits	
			Md. P.G.		C	Capito	ol Height	s				1 Yes 2 No	
			10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cou	ntry?	
		ral	7018 Greig Court # 102							U.S.A.			
920		Completed by Funeral	11. Marital Status  1 □ Never Married 2 □ Marne  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? d 1 Tyes 2 Tyel If Yes, Give Year or Dates:		If	Vas Decedent of H Yes, specify Cuba	ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes or No arto Rican, etc.)		Black, White,	etc.	
21215-0036			15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  9th  College (1-4or 5+)			life. D	rorking	16b. Kind of Business/Industry					
d 2		CO	17. Father's Name (First, Middle, Last)				ustodian	ame (First, Middle,	P.G.Co.School Syst				
Maryland		To Be	James A. Stewart							et Fletcher			
ary							Mailing Address (Street and Number or Rural Route Num						
			John N. Gardner	/Son				ls Dr.,	Capitol H			0743	
nor			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation		cem	netery, crem	sition (Name of natory or other place	1	Date		ition - City or To		
Baltimore,			4 Donation 5 Other (Special Service Li	censee D			Mem. Par Name and Addres H.S. Wash		17/06 & Sons_Co		lover, N		
	*		The state of the s									Approximate	
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):										
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as	a consequer	nce of):							
8760,			cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequer	nce of):							
Box 6			1 Yes 2 No 4 Pregnant at time of death 5 Other (s					pic pregnancy er (specify)			23d. Date of delivery Month Day Year		
P.0			9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death								ne cause of death?		
Records,			239.							1 Yes 2 No 3 Probably 4 Munknown			
al Rec									24a. Was autop perfo	sy	24b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of 2 No	
Vit.		Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	26. Place of Death (Check only one)									
o		n: To	27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred							y)		
ion		Medical Certification:	1 Natural 5 ☐ Pending investiga	tion				(7 Yes 2 ☐ No					
Division of Vital			3 Suicide 6 Could no 4 Homicide determin	t be ed 28e. Place of Inju- building, etc	ury - At home c. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and M n, State)	Number or Rura	al Route Number,	
			29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
			29b. Signature and little of certifier				29c. License	-6		29d. Date s	signed (Month,	Day, Year)	
Ŷ				Add				8957		Ž	-//-	06	
A	-(3)		DR GARY LITT	no completed cause of d	eath (Item 23 0) Hu ar's Signature	3a) (Type, P	AL DR		HEVERLY,	MD	2072	85	
	Sta Registr		31. Date filed (Month, Day, Year)  AUS 1 4 200	32. Registr	ignature	المراجع	<u>ر</u>		,				

			For Stata Registrar				nd / Depa		t of H	ealth a	and M	lental Hyg	iene •9. No <b>20</b> (		27433
	Dharatai		1. Decedent's Name (First	, Middle, La	est)							2. Date of Deat Month	h	/ear	3. Time of Death
	Physici /Medio		John Edwar	d Grov	ve							August	11 200		7:00 p <sup>M</sup>
	Examir	er	4a. Facility Name (If not in	-				4b. City,		Location of		_	4c. County of		~
			Continuum C  5. Social Security Number			ille 7. Age (In yrs.	last birthday)	If Under		esvil If Under		8. Date of Birth		rrol	
	Funeral Director		219-36-0829		M 2□F		76 Yrs.	Months	Days	Hours	Min.	(Month, Day, March 2	Year)	Coun	lace (State or Foreign try)
	pu ,		Usual Residence of Deced	dent								March 2	חרגד סי		
	faryla ehov	5	10a. State 10b.	County <b>Car</b> i	വി	10c. CI	ty, Town or Lo		_					10	0d. Inside City Limits 1 ☐ Yes 2 ☑No
	hours after death with the Maryland turel', or Iteme 23a or 28a-f show il Examiner must be notified at	Director	10e. Street and Number					10f. Zip				1	0g. Citizen of Wh	at Coun	
	3a or	Ö	828 Sprin	a Mill	Road					157				SA	,.
	death	Funeral	11. Marital Status	3	12. Was Dece Armed For	dent Ever in U	J.S. 13.	Was Deced			gin? (Spe	ecify Yes or No- Rican, etc.)	14. Race -	America	
36	or Ite	by Fu	1 Never Married 2		1 ☐ Yes If Yes, Giv	2 <b>∑</b> No 9		1 ☐ Yes 2		Specify:	i, r deito	rican, etc./	Specify:	White, 6	hite
21215-0036	d within 72 hours after death with the Marylan jone r than "naturel", or Iteme 23s or 28a-f show the Medical Examinet must be nailfied at	ed b	3 Widowed 4 D	ecedent's E	Year or Da	ites:		dent's Usua		ation			16b. Kind of Busi		
215	n nat	Completed		highest gra	college (1-	40(5.)	(Give	kind of wor DO NOT us	k done d	during most )	t of worki	ng	TOD. KING OF BUSI	11622/11/0	ustry
212	ed within giene. er than "	Com	11	(0-12)	Conege (1	-401 5+)	Maj	ntena	ince	Depa:	rtme	nt	Board o	E Ed	ucation
nd	be filed tal Hygi d other event, I	Be	17. Father's Name (First, I		)								Maiden Surname)		
yla	should nd Men marke umatic	ို	French S. (		T		401 14 111		/0:			rbaugh			
Maryland	C1 40 70 80		19a. Informant's Name/Re		rype, Printj								City or Town, St	ate, ∠ip	Code)
	s 1 and if Health item 27 other to		Betty Grove 20a. Method of Disposition	/wite_		20b. f	828 Place of Dispo cemetery, crer	SCITE sition (Nam	ig Mi	III P	oad <sub>c</sub>	Westmir	istor, MI 20c. Location - Ci	ty or To	1157 wn, State
E O	Pages ment of I tant: If its jury or o		1 □XBurial 2 □ Cren 1 □ Cren 1 □ Cren			Plate						16/2006	Westmir	nete	r MD
Baltimore,	permit. Page Department i Important: If any injury or		21. Signature of Funeral S		-								pel, P.		L, 145
<u>m</u>	Dep fmp any		* K.S	2 /c	and	Q	41	2 Was	hine	rton I	Road	Westmi	per, P.A	1. 1D	21157
			23a. Part1. Enter the obseshock, or heart failur	ase, or com e. List only	plications that ca one cause on ea	sed the deal	th. Do not ent	er the mode	e of dying	g, such as	cardiac c	r respiratory arre	est,	<u>ر س</u>	Approximate Interval Between
	Pnysician	i o	Immediate Cause (Final disease or condition resulting in death)		a	Ch	SONIC	R	Pno	VI	ne	offreig	ny	1	Onset and Death
	/Medical Examiner	1	resulting in death)	- (	Due to (	or as a consec	quence of):			c. Pc			/		
	+	e.	Sequentially list condition	s,	b. Due to (r	or as a nigrosed	tuence of):	-						_	
	d d ansit	Examiner	Sequentially list condition cause. Enter Underlying Cause (Disease or injury that initiated events	~	0										
ó	sician and burial-transit	Exa	resulting in death) Last	- 1	Due to (d	or as a consec	quence of):								
8760,	# % e	licai			_ d.										
x 68	death certifica e ettending ph id for use as th	Physician/Med	IF FEMALE:		23c. If yes, outo	ama of progra									
Вох	that the death certific ed by the ettending p detached for use as	clan	23b. Was decedent pregn in the past 12 month		1 ☐ Live bi	rth 2 ∐ Feta ant at time of o	al death 3 □	Ectopic pre					23d. Date of Month		ry Day Year
P.O.	the d y the iched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9☐ Unkno		364(1) 3	JOHNE (Spe							
	The law requires that the ste has been signed by th bage 2 should be detache	by Pt	Part II. Other significant of	conditions of	contributing to de	ath but not res	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did tob	acco use contrib	ute to the	e cause of death?
rds	w require been sig should b											1 ☐ Ye	s 2 No 3	☐ Proba	ably 4 □Unknown
Records,	law re as be 2 sho	Completed				_						24a. Was ar		re autop	sy findings available
<u> </u>	The law cete has page 2 s	Com										perform	ied? dea	th?	2□ No
Vital	Physician: Th this certificete ral director, pag	Be	25. Was case referred to examiner?	medical	Haanitali				Oth	-		Check onl one			
of	Phys this ral di	. To	1 Yes 2 No		Hospital: 1 ☐ In 28a. Date o		ER/Outpatien		A Othe Bc. Injury	age I Mul			nce 6 Other		)
O	Jing Afte fune	tion	//	Pending investigation	(Month	n, Day Year)	Injury	M	Work	? ′es 2 ⊡ N		Log. Describe no	w injury occurred		
Division	Atter r dea ector by the	ifica		Could not b	e 28e. Place	of Injury - At h	ome, farm, str	eet, factory,	office		2	28f. Location (Str	eet and Number	or Rural	Route Number,
Ö	tel or s afte el Dir	Certification;	4   Homicide		buildin	g, etc. (Specif	(9)					City or Town	, State)		
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 C	ertifying Ph	ysician: To the i	best of my kno	owledge, death	occurred a	at the tim	e, date and	d place, a	and due to the ca	use(s) and mann ite and place, and	er as sta	ited.
	To the h within 24 To the F complete	Medi	Une)		and mann	er stated.									
1	Co T W T		29b. Signature and title of	11/	1 11	1, .	ν.Λ	290.	License	190111091		29	d. Date signed (I	nonun, D	ay, rear)
	MJL		30. Name and address of	nerson who	completed ausc	of death (Iton	n 23a) (Tune	Print)	10	05	81	5)	8114	101	0
	20		(1) 1611	Con	2951 G	tonor	Aso	St 30	7	411	star	netor	MO -	2115	57
	Sta		31. Date filed (Month, Day			gisaar's Signa		 مر			21				
	Registr	ar	AL	IG 15	2006	Elelva	JF.	4004							

		1 - For State Registrar	State of	Marylan		artment rtificate			and Me	ental Hy	giene Rea. No	200	6	2743	34
		1. Decedent's Name (First, Middle, La	ist)							2. Date of De	ath			3. Time of Death	
Physic /Med		ANNIE L. HA	LL						A	นได้บรา	. Da	, 200	6	9:45 A	М
Exami	ner	4a. Facility Name (If not institution, git WASHINGTON ADV		,	TAL		AKOI	AN				. County of De	MER		
Funera Director		577-34-5237	Sex 7. 1 □ M 2 1 F	Age (In yrs. 7	last birthday) 19 Yrs.	If Under 1 Months	Year Days	If Under: Hours	Min.	8. Date of Bi (Month, D. 'EB	th ry Year) 4,1	9. E	inthplac Country ASH	e (State or Forei	gn •
land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation							10d.	Inside City Limit	ts
Many a-f ah	to	D.C.		WA	SHING	TON								1 XYes 2 □ N	ю
or 28	)ire	10e. Street and Number				10f. Zip (					10g. Cit	tizen of What	Country	?	
ath w	rai	2900 8th St.,	<del></del>			200						TED S			
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland thealth and Mental Hygiene. Item 27 is marked other than "natural; or itams 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Deced Armed Forc 1 Yes 2 If Yes, Give Year or Date	es? Ż¥No	'	Was Decede f Yes, specif 1 ☐ Yes 2	fy Cuban	panic Orig , Mexican Specify:	gin? (Spec i, Puerto F	ofy Yes or No lican, etc.)	)-	14. Race - Ar Black, Wi Specify:	nite, etc		
5-0 72 ho	eted	15. Decedent's E (Specify only highest gr			16a. Dece	dent's Usual kind of work	Occupat	tion uring most	t of workin	a	16b. K	ind of Busines	ss/Indus	stry	
Vithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use	e retired)		or working	g		OD TENT	-		
Hygie thert	e Co	17. Father's Name (First, Middle, Lasi	*)		ADMI	NIST			r's Name	(First, Middle		SPITA	<u>L</u>		
Maryland Id 2 should be file th and Mental Hy 27 is marked oth traumatic avent	To Be	JEFFERY LAWR	ENCE				J	OES:	PHIN	E FIC	KLI	NG			
Te, Mai tand 2 st Health and tam 27 is nother traun		19a. Informant's Name/Relationship STANLEY R. HAL			3607	YENN	VAR	LN.	#2B	., WI	er, City o NDS	or Town, State	, <i>Zip</i> Co LL,	MD 212	44
altimore, mit. Pages 1 ar partment of Hea portant: If Itam y injury or otha		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [	Removal from St	ate C	face of Dispo	natory or oth	ner place			ate .		ocation - City			
Baltimor permit. Pages Department of important: if its any injury or o		4 ☐Donation 5 ☐ Other (Special Signature) of Funeral Service Lice		HAR	MONY	MEM.				06		NDOVE		MD MORTUAI	RV
Balt permit. Departine		Man / hm	an Lake	Vos					•	., NE				N, DC20	
		23a. Part1. Enter the disease, or con shock, or heart lailure. List only	plications that cau	sed the death	n. Do not ent	er the mode	of dying	, such as	cardiac or	respiratory a	rrest,		A	proximate	-
Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or	as a consequence of the conseque	Decor	Tec.	Non	ret	Sis	SA 2 E	•		Ö	terval Between nset and Death	
Examiner		Sequentially list conditions	bue to (or	our To	Jence or):	115	ne	- D	75M	ا					
bed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequ											
\$760, cate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or	as a consequ	uence ol):										
8760, cate be ex physicien a	dicai I	(	d					<u>-</u>							
r 68 artifica ing ph	Med	IF FEMALE:													
Box 6 death certifi	Physician/Me	23b. Was decedent pregnant in the past 12 months?		me of pregna h 2 ∐ Fetal it at time of de	death 3	Ectopic pre						23d. Date of d Month	elivery Da	y Year	
, P.O. I thet the de ted by the a	hys	9 Unknown	9□ Unknow	m											
d be	þ	Part II. Dther significant conditions	contributing to dea	th but not resu	ulting in the ur	nderlying cau	use giver	in Part I.			obacco u Yes 2		to the d Probabl	ause of death?	'n
Record	Completed									24a. Was		24b. Were	autopsy	findings available	le
	Com										rmed?	death	? _		
of Vital F Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		_		-			Check only					
<u>~ ~ ∞</u> <del>0</del>	은	1 Yes 2 No 27. Manne Death	Hospital: 1 Inp		R/Outpatien 28b. Time of		Clours	4 ☐ Nur		e 5 🗆 Resi		6 Other (Sp	ecify)		
Vision Attending or death. actor: After	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month,	Day Year)	Injury	м 200	c. Injury a Work? 1 ☐ Ye	a. es 2 □ N		od. Describe	iow injui	y occurred			
<b>₩ ₽ ₽ ₽ ₽ ₽ ₽ ₽ ₽ ₽ ₽</b>	Certification:	3 Suicide 6 Could not be determined	28e. Place of	Injury - At ho , etc. (Specify	me, larm, stre	eet, factory,	office		28	BI. Location ( City or To	Street an vn, State	d Number or I	Rural R	oute Number,	
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C	29a. Certifier Certifying Pl	nysician: To the be	is of examinat	wledge, death non and/or inv	occurred at restigation, ii	t the time n my opii	, date and nion, deat	d place, ar h occurred	nd due to the d at the time,	cause(s) date and	and manner and di	as state ue to the	d. e cause(s)	
To the vithin To the comple	Me	29b. Signature and title of certifier	-7			29c.	License	number			29d. Dat	te signed (Moi	nth, Day	r, Year)	
		> BM. Cole	year			K	18 5	761	4		81	8/20	06		
2 (3)	r	30. Name and address of person who				Print)		IA, N		2091		1			
	ate	31. Date filed (Month, Day, Year)		istrar's Signat		• / 11	11101			- U J T	_			-	
Regist		AUG 1 4 200			Real	16									

		1 - For State Registrar  1. Decedent's Name (First, Middle,		laryland / Depa <i>Cei</i>	artment of Hertificate of L	ealth and M Death	2. Date of Death	g. No.		27435
Physic /Med Exami	ical	EDWARD M. HAN  4a. Facility Name (If not institution,		·)	4b. City, Town, or	Location of Death	AUGUST	Day 16	2006 y of Death	6:30PM M
Exami	ilei	CORSICA HILLS	-		CENTRI	EVILLE		QUE	EN ANI	TE'S
Funeral Director		5. Social Security Number 219–18–2170	6. Sex 7. A 1 <b>X</b> M 2 ☐ F	ge (In yrs. last birthday)  80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JAN 9,	Year) <b>1926</b>	Cour	lace (State or Foreign htry) YLAND
rryland show		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ecation				1	Od. Inside City Limits
he Ma 28a-f	ecto	MD		BALT			140	- 011	14# 1 0	1 ▼Yes 2 □ No
with t	D.	10e. Street and Number 214 LAURENS ST	THE		10f. Zip Code <b>212</b> ]	17	10	g. Citizen of US		itry ?
72 hours after death with the Maryland 72 hours after death with the Maryland neture!', or Items 23e or 28e-f show digal Exactions must be rediffed at	by Funeral Director	11. Marital Status  1 XNever Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceden Armed Forces	? ]No	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spe	acity Yes or No- Rican, etc.)	14. Ra Bla	ce - Americack, White,	etc.
if e, INIAI yidling ZIZIO-0000  I and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23s or 28s-f show other traumatic event, I'm Medical Exprinter must be notified at	Completed k	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education	16a. Deced (Give life.	dent's Usual Occupa kind of work done di DO NOT use retired) RESIDENT	uring most of worki	ing	6b. Kind of E PUBLI( & MED)	Business/Inc	dustry ATIONS
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should be ind Mental in marked o	To E	EDWARD M. HANR	AHAN, SR.				RANDALL			
MICH YICHTON  10 2 Should be file  11 and Mental Hy  27 is marked oth  17 traumatic event		19a. Informant's Name/Relationsh  R.H. GREENLEE/			ng Address (Street a.  N. WASHING			,		Code)
ges 1 and t of Health If item 27 or other tr		20a. Method of Disposition		20b. Place of Dispo	sition (Name of			0c. Location		own, State
		1 ☐ Burial 2 XCremation 1 ☐ Donation 5 ☐ Other (Sp	3 □Removal from State ecify)	9	natory or other place <b>KE CREMAT</b> ]	1	/18/2006	STEV	/ENSV	LLE, MD
permit. Pages 1 a Department of Hea Importent: If item any injury or othe once.		21. Signature of Funeral Service L	· MER		P. Name and Address FELLOWS, I 200 S. HAI	HELFENBEI				HOME PA
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ficate be executed physician and sthe burial-transit	edicai Examiner	if any, leading to infinediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	c	S a consequence of):						years
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quires that n signed build be deta	by		order				23e. Did toba	acco use con s 2 □ No	ntribute to th	ne cause of death? ably 4 Unknown
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ystcien: The is certificate his director, page	Be	25. Was oase referred to medical examiner?	Hospital:		Othe	26. Place of Death				
	ition; To	1 Yes 2 No  27. Manner of Death  12 Natural 5 Pending 2 Accident investig.	28a. Date of In (Month, D	ient 2 ER/Outpatier iury 28b. Time of ay Year) Injury	28c. Injury Work	4 Nursing Ho	me 5 Resider 28d. Describe hov			γ)
of or Attending after death.  Director: After din by the funer	ertification;	3 Suicide 6 Could n 4 Homicide determin	ned 286. Place of I	njury - At home, farm, str etc. <i>(Specify)</i>	eet, factory, office	-	28f. Location (Stre City or Town,		ber or Rura	l Route Number,
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	dicai C	29a. Certifier Check only one) Certifying	Physician: To the best xaminer: On the basis and manners	t of my knowledge, death of examination and/or in stated.	n occurred at the timi vestigation, in my op	e, date and place, a inion, death occurr	and due to the car ed at the time, dat	use(s) and m te and place,	anner as si , and due to	tated. the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	Wh Vnois	1 nns	29c. License	number	Z = 29	d. Date signe	ed (Month,	
5,11		30. Name and address of person v	ho completed cause of	death (Item 23a) (Type,	Print)	1011				
ノナーマカ		31. Date filed (Month) Day, Year)	manula	nz, East	m, MD	21601				1 600
S: Regis	tate trar	ALIC 1 0 2	A. N	and a Orginature	A,					

State of Maryland / Department of Health and Mental Hygiene 006 27436 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day August 13, 2006 Marie Hamilton 7:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1987 Old Elk Neck Road Elkton Cecil HUnder 1 Year | If Under 24 Hrs. 8 Date of Birth (Months, Day, Year)

Sept. 16, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months 75 204-22-0534 1930 Chester, PA Director Usual Residence of Decedent with the Maryland r 28a-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits Maryland 1 ☐ Yes 2 No Director Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or itams 23a or the Medical Examiner must be 1987 Old Elk Neck Road 21921 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed by 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than Secretary Manufacturing 12 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other eny injury or other treumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Asbury Sipps Bertha Crew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward V. Hamilton 1977 Old Elk Neck Road Elkton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State August 16, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Wesley Chapel 4 Donation 5 Other (Specify) 2006 Elkton, Maryland 21. Signatur - Funy al Service Liver 22. Name and Address of Facility Crouch Funeral Home 127 S. Main Street North East, MD 21901 AL 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on gach line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician 42a1 10m /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by icete has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificete has autopsy performed? 1 ☐ Yes 2 -NO or Attending Physician: funeral director, 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 9 No Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number -80/Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Dimonson

AUG 1 6 2006

31. Date filed (Month, Day, Year)

ORIGINAL

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene  $2\,0\,0\,6$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician Month Judith Hasenei 74 2006 Ann /Medical Facility Name (If not institution, give street and number) 4b. City\_Town, or Location of Death 4c. County of Death Examiner OSPICE Wicomico lisbur oastal The 0 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9/22/1948 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗗 F 57 Yrs Washington, DC 218-54-7554 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23e or 28e-f ehow the Medical Examiner must be notified at Y∏Yes 2 □ No Ocean Pines Directo Maryland Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 42 Castle Drive 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🗷 No δ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Comptroller U.S.Dept. of Navy . Pages 1 and 2 should be filed v tment of Heelth and Mental Hygie tant: if Itam 27 is marked other t jury or other treumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dorothy Anna West Arthur HarveyBoggs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 42 Castle Dr., Ocean Pines, MD 21811 John G. Hasenei Jr./husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 🖾 Cremation 3 □ Removal from State Department o Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Salisbury Crematory 8/14/06 Salisbury, MD Sonature of Juneral Service Licensee <sup>22</sup>Holloway Funeral Home Professional Association 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). The faw requires that the death certificate be executed nding physicien and use as the burial-transit Due to (or as a consequence of) Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 DEctopic pregnancy in the past 12 months? signed by the atte Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s certificate 1 ☐ Yes of Vital Hospital or Attanding Physician: : After this certification : After this certification. 25. Was case referred to medical examiner?\_\_\_/ 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 17 Cratient 1 🗌 Yes Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of leath 28c. Injury at Work? Month, Day Year) 28d. Describe how injury occurred Division Natural 2 Accident s after do. rel Director: Alt 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) gompletely filled in by 4 | Homicide within 24 hours a To the Funsrel [ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) INW eath (Item 23a) (Type, Print) inall, MD F. Coastal BOX 1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

1 5 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene 2.0.0

		1 - For State Registrar  1. Decedent's Name (First, Middle,		-	Certif	icate of	lealth and I Death	2. Date of D	Reg. No			
Physici								Month	Da		2.15	
/Medic Examin		MICHELINA J.  4a. Facility Name (If not institution,			46	City Town o	r Location of Death	AUGUST	12	2 2006 County of Dea		Pivi
LAGIIIII	e	SUBURBAN HO			-		BETHESDA		1			
uneral			Sex 7. Ag	ge (In yrs. last bir		Under 1 Year	If Under 24 Hrs.		lirth	MONTGOME 9. Bi	rthplace (State or Fountry)	oreigi
ector		579-18-8860 Usual Residence of Decedent	1□M 2ÅF	84	Yrs.	onths Days	Hours Min.	MARCH 1	9, 192	22	ITALY	
4		10a. State 10b. County		10c. City, Town	n or Location	on					10d. Inside City	Limits
inotified at	ctor	MARYLAND MONTGON	ÆRY		RO	OCKVILLE					1 ☐ Yes 2	⊠ No
or 28	Director	10e. Street and Number			1	Of. Zip Code		-	10g. Cit	tizen of What C	ountry?	
23a		8 BALTIMORE RO	DAD #212				20850			U.S.A.		
5	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		13. Was	Decedent of H s, specify Cuba	ispanic Origin? (S in, Mexican, Puert	pecify Yes or No Rican, etc.)	lo-	14. Race - Am Black, Whi		
xarri	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	No	10	Yes 2⊠ No	Specify:			Specify:	WHITE	
lical E	Completed	15. Decedent's (Specify only highest	Education	16a.	Decedent'	s Usual Occup	ation during most of wor	kina	16b. K	ind of Business		
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mati	To	FILIPPO SAN  19a. Informant's Name/Relationship		19h	Mailing A	dross (Street	GIOV and Number or Ru	INA BRUNG		or Town State	Zin Co do l	
		SAMUEL SANTINI -									210 0004)	
other tra		20a. Method of Disposition		20b. Place of	Disposition	n (Name of	RIVE, ROCK	VILLE, MA Date		D 20853 ocation - City or	Town, State	
0		1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe	☐Removal from State			ry or other plac EMETERY		T 17,200	6 T1/	CHTMOTON	D. C	
any injury or o	y Y	21. Signature of Funeral Service U	franches L	1111. 01		me and Addre			-	ASHINGTON FUNERAL P	OME, INC.	
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for use as the burial-transit	edicai		d									
NS9 a	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy						23d. Date of de	livery	
	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒ No	4☐ Pregnant at	2 Fetal death time of death		ppic pregnancy er (specify)				Month	Day Yea	īL
	hys	9 Unknown	9□ Unknown									
		Part II. Other significant conditions	contributing to death b	ut not resulting in	the underl	ying cause give	en in Part I.	23e. Did	tobacco u	use contribute to	the cause of dear	th?
should be detached	ted							1 🗆	Yes 2	□No 3□P	robably 4 Dunk	nown
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page 2	S							peri	órmed? 2⊠No	death?	2 □ No	
is certificate has director, page 2	Be	25. Was case referred to medical examiner?	He seiteb				26. Place of Dear	th (Check only	one)			
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completely filled in by the funer.	tion	1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da)		ime ot njury K	28c. Injun Work	at ? Yes 2 □ No	28d. Describe	how injur	y occurred		
y the	ficat	3 Suicide 6 Could not	be 390 Dines of Init	ury - At home, far			res Z INO	28f Location	/Street an	d Number or P	ural Route Number	
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1919 mg	Medicai (	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of aminer: On the basis of and manner sta	examination and	, death occ	urred at the tim gation, in my op	e, date and place, pinion, death occur	and due to the	cause(s) , date and	and manner as I place, and due	s stated. to the cause(s)	
comp	×	29b. Signature and title of certifier	,			29c. License	number		29d. Dat	te signed (Mont	h, Dey, Year)	
		1 deen	2			D378	91		AUGII	ST 13, 20	006	
		30. Name and address of person with	o completed cause of d	eath (Item 23a) (	Type, Print					,		
		AMIT KUMAR RAJVANSH			ONAL LA	NE, SUIT	E 40), ROC	KVILLE N	1ARYLA	ND 20852		
Stat		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	Acces	6,						
Registra	-1	AUG I 9	2006	50 Di	AST REAL S							

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death Date Month 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 **Physician** JACKSON Α. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Hospice at the Wicomico oastal ake If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F Days Months Hours Director Yrs. 58 DEC.6, 216-50-5565 1947 WASHINGTON, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "naturel", or itema 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2 🙀 No DELAWARE SUSSEX DAGSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 34402 INDIAN RIVER DRIVE 19939 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) TEACHER'S AIDE SCHOOL DISTRICT permit. Pages 1 and 2 should be filed to bepartment of Heelih and Mental Hygie important: if item 27 is marked other till any injury or other traumatic event, Impore. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ARNO M. REED MARGARET M. DIEMAND ဂ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD D. JACKSON, II/HUSBAND 34402 INDIAN RIVER DRIVE, DAGSBORO, DE 19939 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) EASTERN SHORE CREMATORIUM 108/14/2006 LEWES, DELAWARE MO0866 21. Signature of Funeral Service Licensee PARSELL TUNERAL HOMES & CREMATORIUM, CLARKSVILLE CHAPEL ROUTES 26 & 17, CLARKSVILLE, DE 19970 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC Physician CARCINOMA OF BREAST /Medical Examiner Sequentially list conditions, dary leading to innectate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) detached Ö 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Ho 24a. Was an autopsy performed? Yes 2 No 1□ Yes : After this certifications a funeral director. 25. Was case referred to medicat examiner? Be 26. Place of Death | Check only one) Hospital: 1 Impatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 2 📉 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 28b. Time of Injury 28c. Injury at Work? Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after dea. rei Director: Aftr 1 ☐ Yes 2 ☐ No 2 - Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00058410 8/13/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARIS ARROWWOOD CT SALISBURY UN 21801 -HULAM 26266 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State Registrar 5 2006

06-06049 Richard Kimball

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 27440

Description   Description			Registrar			Certific	ate of	Death			F	Reg No.	-	UU	0 214-
August 14, 2006  August										2			Year		
Provided   Provided	Medical Exam	ıner	MINING KIND									4, 200	6		1835 hrs
Process   Proc					id number)		41		ocation of	Death			-		-
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Use of Members of Decreement   Tick Robbins   Document   Tick Robbins   Tick R	Director		156-67-6666	1 X M 2	F	50	Yrs	Wioritins Days	Hours	IVBIT	Sept.	18,	1955	Cou	ntry) York
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2002 Roanoke Street  1   Security Street   12   More Married   2   More Interest Even U.S.   3   More Married   2   More Interest   2   More Inter	land f sho	50		ce Georg	ge's	Hyatt	svil:	e							1 X Yes 2 No
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Second Company   Seco	h with	era		A		er in U.S.	13. Was	Decedent of Hisp	anic Origin	1? (Spec	ify Yes or No	o-			an Indian, Black,
Second Company   Seco	deat or ite	un-		1 Y	es 2 X	No				deno Ki	carr, etc.)		vvriite,	etc.	
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Supervision of the supervision o			failure. List only one caus	e on each line.	iai causeu irie	death, Do no	n enter the	mode of dying, si	uch as can	diac or re	sspiratory arr	est, sno	ck, or near	t	Between Onset and
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State  Suicide  Suici	Bo deat	Ş	1 Yes 2 No 9 U	ıknown 9 U	nknown		out	(							
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State  Suicide  Suici	rest signe bed	a P				-					1 Yes	2 🗸	No 3	Proba	oly 4 Unknown
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State  Suicide  Suici	n: TP tifica or, pa		25 Was case referred to medic	al				26 Place o	f Death (C	heck only		2 <b>N</b> o	1	/ Yes	2 No
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296. License number O.C.M.E.  29d Date signed (Month, Day, Year) August 15, 2006  The Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year) Registrar's Signature	fospi 4 hou 7 mer ely fil		20- 0-46	hysician: To the	hast of my kn	owledge des	th occurre	d at the time, date	and place	1 0000	- 4- 40	- (-)			
296. License number O.C.M.E.  29d Date signed (Month, Day, Year) August 15, 2006  The Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year) Registrar's Signature	the land 2 the F	lica	one) 2 Medical Ex	aminer:On the ba	sis of examina	ition and/or in	vestigation	n, in my opinion, c	eath occur	rred at th	e to the caus e time, date	and plac	a manner a ce, and due	s started to the d	t cause(s)
O.C.M.E. August 15, 2006  Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year)  Registrar's Signature	To To con	Mec		and mann	er stated	-									
Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year) Registrar's Signature Registrar's Signature			/ // a. /	la	)			1				i			, 20, 100,
Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year) 7 Registrar's Signature		- (	Thomas and address at a con-	who	nounce of death	/Itom 20:1						L.""			
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Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certif	icate of	Death				1006 2741
Physicia edical Exami	an/	1 Decedent's Name (First, Middle ANTHONY CHU	NGHO KIM					2. Date of Dea Month August 1	Day Yea 1, 2006	2344 nrs
The same of the sa		4a. Facility Name (if not institution 10000 Baltimore Ave.	n, give street and number)		4	b. City, Town, or Beltsville	Location of De		4c. County of Prince G	George's
Funeral Director		214 23 6132		(În yrs. last l	birthday) Yrs.	If Under 1 Year Months Days		Ain.	rth(MM/DD/YYYY R 1, 1984	) 9. Birthplace (State or Foreign Country) KOREA
Maryland 28a-f show any 1 at once.	tor	Usual Residence of Decedent  10a State 10b. County WOWARD  10e. Street and Number	1	0c. City, To	wn or Location	n 10f. Zip Code			10. 67	10d Inside City Limits 1 X Yes 2 No
h the Mary 3a or 28a otified at	Director	6929 PARCHMEN	T RD			21044			10g. Citizen of Wh	at Country?
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene rited other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	by Funeral	3 Widowed 4 Divo	orced If Yes, Give Year or Dates:	X No	If Ye	s, specify Cuban Yes 2 X No	specify	·	White	ASIAN
5-0036 led within 72 hour Hygiene. other than "natu	Completed	15. Decedent's Education (Spec Elementary/Secondary (0-12) 12	College (1-4 or 5+			s Usual Occupat st of working life. NT			PRIVAT	ŕ
21215-0036 utilin 7 Mental Hygiene. marked other than ic event, the Medical	Be	17. Father's Name (First, Middle, KI KIM			e = h=q=		HYON	KIM	Maiden Surname)	
O ≒ 5 ± 1	ᅀ	19a Informant's Name/Relationsh KI KIM /FATH 20a Method of Disposition		[6	5929 P	ARCHMENT	RD C	OLUMBIA N	MD 21044	n, State, Zip Code)
Baltimore, ME permit Pages I and 2 s Department of Health a Important: If item 27		1 Burial 2 X Cremation 4 Donation 5 Other Sp	ecify:	cren	natory or othe APEAKE	CREMATO	ORY 8	Date /16/06	BELTSV	City or Town, State
Balt permit Depart Impor		21. Signature of Fun, par ervire l	ude		12	ame and Address	K DR UI	PPER MARI	LBORO MD	ERAL SERVICE 20772
Physician /Medical Examiner		23a. Part I. Enter the disease or diallure. List only one cause of Immediate Cause (Final disease	complications that caused the each line.  a. Intraoral Gunshel		not enter the	e mode of dying, a—oral sho	such as cardia	c or respiratory arr	est, shock, or hea	Approximate Interval Between Onset and Death
· LAdillillei		or condition resulting in death)  Sequentially list conditions,	Due to (or as a conseq	uence of):						
ı	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	Due to (or as a conseq c. Due to (or as a conseq							
8760, tificate be executed ng physician and as the burial - transit	n/Medical E	UNPENDED	X AMENDED #22-	MC	-0(0 1	10/16/06 T	TT			
8760, tificate be ex. ng physician as the burial	Med	IF FEMALE:	#23a,	perivit,	g862, J	12/16/06 T	T		23d. Date of o	delivery
	jan/l	23b. Was decedent pregnant in the past 12 months?	Dropport of the		2 Feta	al death 3	Ectopic preg	gnancy	Month	Day Year
Box 6  death cer the attendi	Physicia	1 Yes 2 No 9 Unki	9 Unknown		3 Otti	er (Specify)				
, P.O. Box 6 rres that the death cer signed by the attendi be detached for use.	ρ	Part II. Other significant condition	ons contributing to death t	out not resul	lting in the ur	iderlying cause g	iven in Part I.			bute to the cause of death?  Probably 4 Unknown
of Vital Records, ng Physician: The law require Wher this certificate has been si meral director, page 2 should t	Completed							24a Was autop perfo	osy pr	Vere autopsy findings available rior to completion of cause of eath?
Re ificate		25. Was case referred to medical	<del></del> r			26 Diago	of Death (Chec	1 🗸 Yes		Yes 2 No
Vital hysician: this certif	o Be	examiner?	Hospital: 1 Inpatient	2 ER	l/Outpatient		Other:		Residence 6	Other Scene
C = _ \ 4	-	27. Manner of Death  1 Natural 5 Pendi		r) FC	b. Time of Inj		y at Work?		how injury occurre	:d
Division spital or Attendi- tours after death neral Director: /	Certification:	3 Suicide 6 Could	tigation Aug 11, 2006 28e. Place of Injur Specify Hote	y - At home	230 hrs e, farm, street	, factory, office bi	uilding, etc.	or Town, S		er or Rural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a Certifier 1 Certifying Ph	ysician: To the best of my lininer: On the basis of exami	nowledge, on and/o	death occurre or investigation	ed at the time, da on, in my opinion,	te and place, a death occurred	nd due to the caus	se(s) and manner :	as started.
<b>2</b>	Me	29b. Signature and little of certifier		1		29c. License	number		29d. Date signe	ed (Month, Day, Year)
00		30. Name and address of person	who completed lause of dea	ath (Item 23s	a)	O.C.N	И.Е. 		August 12,	2006
ULL	6	Susan Hogan MD. A	Assistant Medical Exa	miner	,	Street, Balti	more, MD 2	21201		
St Regist		31. Date filed (Month, Day, Year) AUG 1 5 20	Registrar's	Signature	Goods	1				

		•	For State Registrar	State of M	aryland / De <sub>l</sub>	partment of Fertificate of	lealth and Death		iene2 0 0	6 27442
	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Deat Month	h Day Y	3. Time of Death
	/Medic	cal	ANNA THERE  4a. Facility Name (If not institution, gir		ACKO	4b. City, Town, o	Location of Dea	AUGUST	19 200 4c. County of	10.13 1
	Examir	ier	ST. MARY'S NUR		R	LEONAR				MARY'S
	Funeral		Social Security Number 6.		e (In yrs. last birthda		If Under 24 Hr. Hours Min			Birthplace (State or Foreign Country)
S.	Director		206-32-8413 Usual Residence of Decedent	TLIM ZLAF	93 Yrs.			8-22-19	12 P	ennsylvania
	yland Now		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	e Mar	ctor	Maryland St. Ma	ry's		harlotte	Hall			1 ☐ Yes 2 No
	vith th	Director	10e. Street and Number			10f. Zip Code			0g. Citizen of Wha	•
	eath v	eral	30145 Bach Driv	12. Was Decedent	Ever in U.S. 11	2062			United S	tates American Indian,
36	72 hours after death with the Maryland naturel', or Itema 23a or 28a-f ehow dical Examinar must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 4 If Yes, Give Year or Dates:		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	rto Rican, etc.)		White, etc. White
2-0	hin 72 hou s. n. "nature Madical E	Completed	15. Decedent's E (Specify only highest gr		16a. Dec	cedent's Usual Occup	ation	odkina	16b. Kind of Busin	
121	within ene. then "	mple	Elementary/Secondary (0-12)	College (1-4or	lite	. DO NOT use retired	1)	J. Karg		
d 2	Hyginther ther	e Co	10 17. Father's Name (First, Middle, Las	t)		Homemaker	18. Mother's Na	ame (First, Middle, I	Own Ho	me
lan	a ta b	To B	Andrew Sabol					abeth Hlu		
Maryland 21215-0036	C1 (0) = 68		19a. Informant's Name/Relationship			iling Address (Street			-	
e, ⊾	1 and 1ealth 1m 27 ther to		Charles R. Kopac	ko/Son		5 Bach Dr	ive, Cha			
Baltimore,			1 Burial 2 ☐ Cremation 3 [		cemetery, c	ematory or other place	1		20c. Location - Cit	
Hin	48to.		4 ☐ Donation 5 ☐ Other (Special States of Fundamental States of Fundamental States of Special States of States of States of Special States of Sta			opius Cem			lew Salem Echols F	uneral Home
ñ	Depa Impo eny is		Edward N. Brinsf							11, MD 20622
F	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each li	d the death. Do not ene.		_			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
Ì	A Town	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
8760,	cate be executed oblysicien and the burial-transit		that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					
Box 6	death certifi e attending p d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	BEctopic pregnancy			23d. Date o Month	
rds, P.O.	Se Co e	þ	Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause giv	en in Part I.	23e. Did tob	_	ite to the cause of death?  Probably 4 □Unknown
of Vital Records,	e law has b	Completed						24a. Was a autops perform	y prio ned? dea	e autopsy findings available r to completion of cause of th? Yes 2 \sum No
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			le:		eath (Check only on		
of \	ys dir	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatie			4 Jursing	Home 5 Reside		(Specify)
on	ding h. After fune	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) 200. Time	Wor	k? Yes 2 □No	28d. Describe no	w injury occurred	
=	in Ute	ertification:	3 Suicide 6 Could not 6 4 Homicide determined	286. Place of In	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (St. City or Town	reet and Number of, State)	or Rural Route Number,
3	To the Hospital or Al within 24 hours after of To the Funerel Direc completely filled in by	edical C	29a. Certifier 1 certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	examination and/or	ath occurred at the tir investigation, in my o	ne, date and place pinion, death occ	e, and due to the ca curred at the time, da	ause(s) and manne ate and place, and	er as stated. idue to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier		012	29c. Licens	e number	25	9d. Date signed (A	Month, Day, Year)
•			MON	le Elle	1711)	2)	5076		8-71.	- 06
			30. Name and address of person who	GILL	leath (Item 23a) (Typ	ASSOCIA	135	LEWAL	TOWN	MD
iX-	Sta Registr		31. Date filed (Month, Dax. Year)	006 37 Registr	ar's Signature	and a				

			T = For State Registrar	State of M		artment of Health and rtificate of Death	d Mental Hygie Reg.	ZUUD Z/443
egit .	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Las     Emory Russell Ker      4a. Facility Name (If not institution, give     St. Mary 's Hospit	r street and number)		4b. City, Town, or Location of D	August 2	Day Year 2006 12:35 P M 4c. County of Death
	Funeral Director		5. Social Security Number 579-03-4344 6. Se		e (In yrs. last birthday) 87 Yrs.	Leonardtown If Under 1 Year If Under 24 H Months Days Hours N	lin. (Month, Day, Ye	St. Mary's  9. Birthplace (State or Foreign Country)  1918 Indiana
	the Maryland 28a-f show	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland St. Mary  10e. Street and Number	S	10c. City, Town or Lo		100	10d. Inside City Limits 1 □ Yes 2 No  Citizen of What Country?
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Itams 23e or 28e-f show event, the Madical Examinar must be notified at	Completed by Funeral Di	45715 Stoney Run I	12. Was Decedent Armed Forces?  TY Yes 2 1 If Yes, Give Year or Dates:	No 16a. Dece	20634  Was Decedent of Hispanic Origin' I'Yes, specify Cuban, Mexican, Pi I'Yes X No Specify:  dent's Usual Occupation kind of work done during most of DO NOT use retired)	Uni (Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21	should be filed withind Mental Hygiene. I marked other than umatic event, the Mental Men	To Be Corr	12 17. Father's Name (First, Middle, Last) Ezra Kerr		Motor	Ada 1	Name (First, Middle, Maid Eskew	
Baltimore, Mar	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic <u>once.</u>		19a. Informant's Name/Relationship (T. Michael Russell Ke 20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Sign that Toperal Struce Cooperation No. 1971ns	rr/Son Removal from State	20b. Place of Dispo cemetery, crem St. Michae	sition (Name of natory or other place) Aug el's Cemetery	ve, Great Mi gust 25, 2006 Ri Brinsfield F	.11s, Maryland 20634 .Location - City or Town, State .due, Maryland
58760,	Cate be executed /Medical Examiner the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last	Due to (or as	the death. Do not ent ne.	er the mode of dying, such as care		Approximate Interval Between Onset and Death
P.O. Box 68		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use a	Completed by P	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the ur	nderlying cause given in Part I.	1  Yes  24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
Division of Vital Records,	sing Physician:  After this c∈rtifice funeral director, i	To Be	25 Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatie 28a. Date of Inju	ry 28b. Time of	t 3 DOA Other: 4 Nursing	1 Yes 2 A Death (Check only one)  g Home 5 Residence 28d. Describe how in	6  ☐ Other (Specify)
DIVIS	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral completely filled in by the funeral completely filled in by the funeral completely filled in by the funeral completely filled in the funer	cal Certification:	3 Surcide 4 Homicide  29a. Certifier  1 Certifying Phy	building, etc	of my knowledge, death	occurred at the time, date and pla	City or Town, St.	a/s) and manner as stated
)	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of certifier	and manner sta	examination and/or inv	29c. License number	ccurred at the time, date a	and place, and due to the cause(s)  Dat, signed (M. nth, Day, Year)
	Sta Registr	4.0	30. Name and address of person who control of the state o	ompleted cause of discourse of	eath (Item 23a) (Type, Control of the Control of th	ourt Leon	ard town	mp 30020

land / Department of Health and Mantal Husiana 2006 0711	
land / Department of Health and Mental Hygiene 2006 2744	4

			1 - State Registrar	State of Maryland	Cei	artment of H tificate of L	eaith and M D <i>eath</i>		g. No.	5 2/441
	)4 Discontint		1. Decedent's Name (First, Middle, Last)			-		2. Date of Death Month	n Day Year	3. Time of Death
	Physici /Medio		Mark Victor Kis	sal					10, 2006	1:30 a M
	Examin		4a. Facility Name (If not institution, give s				Location of Death		4c. County of Dea	th
			Holy Cross Hospita  5. Social Security Number 6. Sex	7. Age (In yrs. Ia:	n t himbolous)	Silver If Under 1 Year	Spring If Under 24 Hrs.	8. Date of Birth	<u> </u>	omery
	Funeral Director			M 2□F 77	Yrs.	Months Days	Hours Min.	(Month, Day,	1	thplace (State or Foreign ountry) hington, DC
	yland		10a. State 10b. County District of	10c. City,	Town or Lo	cation				10d. Inside City Limits
	a-f al	ctor	Columbia N/A	Was	hingto	on				1 ∑Yes 2 ☐ No
	or 28	Oire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	ath w	rail	4201 47th Street,		1	20016			USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23e or 28e-f show may njury or other traumatic avant, Ita Medical Exaction must be rectilined at ODGs.	Completed by Funeral Director	11. Marital Status  1 TNever Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? MTYes 2 □ No If Yes, Give 5/10/1 Year or Dates: 5/09/1	951	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 24☐ No	spanic Origin? (Spe n, Mexican, Puerto F Specify:	city Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify.Whi	te, etc.
2-0	72 hc	eted	15. Decedent's Educ (Specify only highest grade			dent's Usual Occupa	ition luring most of workin	ng 1	6b. Kind of Business	/Industry
121	within ane. than "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired rical Wor		I	Pepartment	of the
	filed Hygie other	o C C	17. Father's Name (First, Middle, Last)		0101	ricar mor	18. Mother's Name		Army faiden Sumame)	
Maryland	lid be lental rked o	To Be	Victor Konstantin	e Kissal			Cleo V.	Polyxror	opoulos	
ary	shou and N		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street a			City or Town, State,	Zip Code)
	and 2 salth an 27 i		Mary E. Palmer/ N				Road, Si	-	ing, MD 20	
Baltimore,	Pages 1 ment of He tant: If Iten jury or oth		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	netery, crer	sition (Name of matory or other place an Cremator	a)   Augus	t. 11.	20c. Location - City or Alexandria	Town, State , Virginia
Salt	permit. Departr Importi any inje		21. Signature of Funeral Service License	4	F	Name and Addres	set Facilities :	Funeral	Home Inc.	
	<u>0</u> 0 = 0		No con participation of the control	Tulu						g, MD 20901
	Physician /Medical Examiner		23a, ant. Enter the distase, or couplic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Renal Failu:	re ence of):		g, such as cardiac of	r respiratory arre	st,	Approximate Interval Between Onset and Death
		ner	Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury	Diabetic Neg		thy				
	ecufec and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to for on a conseque						
68760,	tificate be execufed ig physicien and as fhe burial-transif	edical Ex	d	Due to (or as a conseque	ence or):					
	ertific ling pl		IF FEMALE:							
P.O. Box	res thef the death cert igned by the attendin be detached for use	Completed by Physician/N	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	ic. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of deaged Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	equires thef fhe een signed by fh ould be detache	y Pt	Part II. Other significant conditions conf	ributing to death but not result	ting in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
ığ	w require been sig should b	ted						1 □ Ye	s 23⊠No 3∏P	robably 4 Unknown
I Records,	e law i hes bo	Somple						24a. Was ar autopsy perform 1 \square Yes 2	prior to death?	utopsy findings available completion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?			Tou	26. Place of Death	Check only one	)	
of/	di S	2	1 162 5 2 3 140		R/Outpatier		4 Livursing Hon		nce 6 ☐Other (Spe	ecify)
Division of	Attending F r death. octor: After by fhe funer	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	28b. Time of Injury	M 1 🗆 Y	/es 2□No		w injury occurred	
Divi	al or At s affer o	Sertifi	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)		eet, factory, office	2	8t. Location (Str City or Town	eet and Number or R , State)	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier (Check only one) 1 ☑ Certifying Phys 2 ☐ Medical Examin	ician: To the best of my know er: On the basis of examination and manner stated.	ledge, death on and/or in	n occurred at the tim vestigation, in my op	e, date and place, a sinion, death occurre	nd due to the ca ed at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
		Σ	29b. Signature and title of certifier	Idie D.C	) .	29c. License HOO	number 06455		d. Date signed (Mon	
1	2+1		30. Name and address of person who cor Ashish Tolia, D.O.				ilver Spr	ing, MD	20910	
Total State	Sta Registi		31. Date filed (Month, Day, Year)	32. Begistrar's Signatu	re	anti				
			7.00000 0 60	Marie Ju						

	1 - For State Registrar	State of Maryland	Certifica	ate of D	eath	1	Reg. No.	2006	2744
N.	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of Death
ysician	IN CHAN KIM					Month August	Day 12	Year 2006	7:36 P <sup>M</sup>
ledical aminer	4a. Facility Name (If not institution, give s	street and number)	4b. C	ity, Town, or I	Location of Deat			County of Death	7.30 1
aiiiiiei	Holy Cross Hospita	1	9	ilver	Spring			Montgome	o <b>r</b> w
orol .	5. Social Security Number 6. Sex			der 1 Year	If Under 24 Hrs	8. Date of Birt		9. Birth	place (State or Foreign
eral ctor		M 2 <b>⊠</b> F 79	Yrs. Monti	ns Days	Hours Min.	(Month, Da April 2	y, Year) 96 10	Cou	ntry)
	Usual Residence of Decedent					Whiti 5	.0 1 7	ZI KUL	ca
<b>a</b>	10a. State 10b. County	10c. City,	Town or Location						10d. In side City Limits
9 5	Maryland Montgomer	rv Whe	aton						1 ☐ Yes 2X No
eny injury or other traumatic event, the Medical Examinar must be notified at since.  To Be Completed by Funeral Director	10e. Street and Number			Zip Code		·	10g. Citiz	en of What Cou	ntry?
	11502 B -111 D	d		20902			TT	S.A.	
Funeral	11503 Bucknell Dr.	12. Was Decedent Ever in U.S.	13 Was De		nanic Origin? (S	Specify Yes or No		4. Race - America	can Indian.
ج ا	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No	If Yes, s	specify Cuban	, Mexican, Puer	Specify Yes or No- to Rican, etc.)		Black, White,	
by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Ye.	s 2⊠ No	Specify:			Specify: As:	ian
P	15. Decedent's Edu		16a. Decedent's U	leual Occupa	tion		16h Kin	nd of Business/In	dusto
Completed	(Specify only highest grade		(Give kind of life. DO NO	work done du	iring most of wo	rking	IOD. Na	id of business/in	ladistry
를	Elementary/Secondary (0-12)	College (1-4or 5+)	_	,			ъ		. +
ပိ	17. Father's Name (First, Middle, Last)		Entrep			me (First, Middle,		estaura	.IL
Be							maiden :	Sum <b>a</b> me)	
ဥ	Una Kwon Kim				Kumnie				
10.0	19a. Informant's Name/Relationship (Ty		19b. Mailing Addr						
	Sunhi Chough/Daug		9700 W11			omac, Ma	ryla	nd 20854	+
	20a. Method of Disposition	20b. Plac	e of Disposition (interest, crematory)	Name of or other place	)	Date	20c. Loc	cation - City or To	own, State
/	1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	IOITIOVALITOTTI STATO	eck Mem.		I	6/2006	01ne	y. Maryl	Land
á	21. Signature of Funeral Service License								
	Na A		HINES	-RINAL	DI FUNE	RAL HOME	, IN	U. r Sprine	g, MD 2090
	23a Part 1. Enter the disease or compli	ications that caused the death.						r phriis	Approximate
	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final	ne cause on each line.		_ , ,		, ,			Interval Between Onset and Death
י	disease or condition resulting in death)	Anoxic Encep	halopath						
l r	rosuming in dealthy	Due to (or as a consequer	nce of):						
	Sequentially list conditions,	Noncommunive		Epilep	ticus				
lier	Suggestially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequen	nce of):						
Examin	that initiated events resulting in death) Last								
ω ω	resulting in death) Last	Due to (or as a consequer	nce at):						
dlcal		1.						_	
1 00	IE EE MALE.						I	1	
Physician/M	23b. was decedent pregnant	3c. If yes, outcome of pregnanc 1□Live birth 2□Fetal de		c pregnancy			2	3d. Date of deliv	,
cja	in the past 12 months? 1 ☐ Yes 2 🖾 No	4 Pregnant at time of deat						Month	Day Year
S	9 Unknown	9□ Unknown							
J.	Part II. Other significant conditions cor	ntributing to death but not resulti	ng in the underlyin	ig cause give	n in Part I.	23e. Did to	obacco us	se contribute lo t	he cause of death?
dby	Chronic Renal Fa		,	-		1127	res 2[	No 3□Prot	bably 4 ∐Unknown
stec	17	TIULE							
Completed	Hypertension					24a. Was autop	SV	24b. Were auto	opsy findings available impletion of cause of
PO						penfo 1 ☐ Yes	rmed?	death? 1 ☐ Yes	2 No
O	25. Was case referred to medical			-	26. Place of De	ath Check only o			
OB	examiner? 1 ☐ Yes 2 🔯 No	lospital: 1⊠Inpatient 2□EF	VOutpatient 3□	DOA Othe		dome 5 Resid		Other /Specia	fu)
	27. Manner of Death	28a. Date of Injury 21	8b. Time of	28c. Injury Work		28d. Describe			777
후	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury M		? es 2 □ No				
Sa	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hom	e farm street fan			28f Location /5	Street and	Number or Run	al Route Number.
ertification;	4 Homicide determined	building, etc. (Specify)	o, railli, street, rac	iory, ornice		City or Tox	vn, State)	THE THE TEN	ar riobto ridiniber,
O		1							
edical	(Check only 2 Medical Exemi	sicien: To the best of my knowle ner: On the basis of examination	eage, death occur n and/or inve <i>s</i> tigat	red at the time tion, in my op	e, date and place inion, death occi	e, and due to the urred at the time.	cause(s) date and	and manner as a place, and due to	stated. o the cause(s)
1 70	one)	and manner stated.							
<u>o</u>	29b. Signature and title of certifier	711111111		29c. License	number		29d. Date	signed (Month,	Day, Year)
Me									
Me	· mm	and and		DR-63	579		Augi	ıst 14.	2006
Me	30. Name and address of person who co	ompleted cause of death (Item 2	3a) (Type, Print)	DR-63	579		Augu	ıst 14,	2006
Mec	30. Name and address of person who co			88.000		May-1	100		2006
State	30. Name and address of person who command Tayar, MD.  31. Date filed (Month, Day, Year)		en Road,	Silve		g, Maryla	100		2006

-			1 - For AMEND#8per INF 8/2 Registrar AMEND#20b, cpe	23/06, HW, MO rFH8/16/06, BM	www.moco	Cer	tificate	of Death	mental Hy	/giene Reg. No.	2006	27446
	Physicia	an	Decedent's Name (First, Middle, La	ast)					2. Date of D Month	eath Day		3. Time of Death
	/Medic		RIN KHIM						AUGUST	11	2006	12:17 P M
	Examin	er	4a. Facility Name (If not institution, give					wn, or Location of Death	1	46.	County of Dea	
11/2	in the second		HOLY CROSS HOSPITAL  5. Social Security Number 6.5		e (In yrs. last bir	thday)	If Under 1 Y	LVER SPRING rear   ff Under 24 Hrs.	8. Date of B	rth	MONTGOMI 9. Bir	ERY thplace (State or Foreign ountry)
	Funeral Director			1□M 2ØF		Yrs.	Months D	ays Hours Min.	(Month, D FEBRUAR)	ay, <b>2</b> ear) 1		MBODIA
7	>		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits
oly o	oho v	5			Toc. Oity, Tow							1 ☐ Yes 2 X No
d of	28a-	Director	MARYLAND MONTGOME  10e. Street and Number	ERY			SILVER S			10g. Citi	zen of What Co	juntry?
booken with the Mandage	3a or	0	3408 MAY STREET					20906		C.	AMBODIA	
toop	ms 2	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. V	Was Decedent	t of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or N	0-	14. Race - Ame Black, Whit	
	or Ite	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:	No	i	1 ☐ Yes 2 🔀		o 7		Specify:	ASIAN
3-003c	sal Ex		15. Decedent's E	ducation	16a	Deced	dent's Usual C	Occupation		16b. Ki	nd of Business	
C 17	n u	Completed	(Specify only highest gr Elementary/Secondary (0-12)	rade completed)  College (1-4or 5	i+)	(Give I	kind of work o DO NOT use r	done during most of wor retired)	king			
7	e the	Com	7			1	HOME MAK				OWN HOME	3
	d oth	Be	17. Father's Name (First, Middle, Last	t)				18. Mother's Nan		e, Maiden	Sumame)	
<u> </u>	d Men narke	P	KHIM YI	/Tuna Brint	106	Mailin	Addross /S	treet and Number or Ru		hor City o	r Town State	Zin Code)
2 2	Ith and 27 le r		19a. Informant's Name/Relationship THOUCH SIENG - SON		190		,	REET, SILVER				2/0 0008/
į -	f Hea frem other		20a. Method of Disposition		20b. Place o	Dispos	sition (Name	of	Date	20c. Lo	cation - City or	
aiminor	nent o		1 ☐ Burial 2 🖾 Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci		Riverca CHESAPI	e Pa	CREMATO	AUGUS	19,2006	BELI	dale, Ma SVILLE,	MARYLAND
Dail	permit. Tages I am 2 should be waiting to hous after death with the was year population. I health and Maria Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s-1 show eny injury or other traumatic event, in Medical Examinational invalidation.		21. Signature of Funeral Serv	nse	au-			Address of Facility HAMPSHIRE AV	HINES-RIN ENUE, SII			
1	. •		23. Part1. Enter the disease, or con shock, or reart failure. List only Immediate Cause (Final	nplications that caused y one cause on each lin	the death. Do							Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	w	EREBRAL H		RHAGE					SUDDEN
	xaminer			HYPERTI		OI).						YEARS
	, =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence	of).						
9	and transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (er se	a consequence	of):						
S,	physicien and ts the burial-transit			200 (0) 43	a consequence	<b>01</b> ).						
00/00	p phys	edical		d								
XOD I	ending r use a	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Petal death	3 [	Ectopic pregr	nancy		:	23d. Date of de	·
. 7	Mequiles trial ribe death centre been signed by the attending should be detached for use a	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown			Other (speci				Month	Day Year
ָ כ	ed by th detache		Part ff. Other significant conditions	contributing to death b	ut not resulting i	n the ur	nderlying caus	se given in Part f.	23e. Did	tobacco u	ise contribute to	o the cause of death?
	ed place	d by	DIABETES MELLITUS				, ,		10	Yes 2	□No 3□P	robably 4 ∑Unknown
ecords	as beer 2 shou	Completed					·		24a. Wa		24b. Were a	utopsy findings available
ב ב	D - 0	omp							aut per 1□ Yes	opsy formed? 2 🖾 No	prior to death?	completion of cause of
	certificate	BeC	25. Was case referred to medical examiner?		, , , , , , , , , , , , , , , , , , , ,			26. Place of Dea				
	<u></u>	2	1 Yes 2 XNo	Hospital: 1 🔯 Inpatie	ent 2 ER/O	_		<del></del>	lome 5 Res			ecify)
_ (	n நெற		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year) 28b.	Time of fnjury	M 28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injur	y occurred	
Division	or Atter fiter dee Director in by the	ertification:	3 Suicide 6 Could not 4 Homicide determined	be 28e. Place of fnj building, et		arm, str	eet, factory, o	ffice	28f. Location City or To	(Street an own, State	d Number or R )	lural Route Number,
	To the Hospital or Attending within 24 hours after deeth.  To the Funeral Director: After completely filled in by the fun	edical Ce	(Check only 2 Medical Exa	aminer: On the basis o	f examination ar			the time, date and place my opinion, death occu				
	ithin 2 o the i	Med	one) 29b. Signature and title of certifier	and manner sta	ateg.		29c. L	icense number		29d. Dat	te signed (Mon	th, Day, Year)
	- ≯ <del>-</del> 8		Shopa	un	-		ת	32332		Alici	FCT 11 2	006
1			30. Name and address of person who		leath (ftem 23a)	(Туре,		J_J_J_&		AUGU	IST 11, 2	000
			SURESH K. GUPTA, M.	D., 9801 GEOF	RGIA AVENU	JE, S	SILVER S	PRING, MARYLAI	ND 20902			
	Sta Registi		31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	do	we					

State of Maryland / Department of Health and Mental Hygien 2006 27447 For State AMEND#15, perFH, 8/15/06, DES, McCo. Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5:35 A. M August 2006 **Physician** Arthur Clinton Kellogg /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 6710 Tildenwood Lane Rockville If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Year **Funeral** 1 M 2 □ F 98 011-09-3355 1,1907 Massachusetts Director Usual Residence of Decedent the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-1 ehow f Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23a or 28a-1 ehov other traumatic event, the Madical Examinar must be notified at Rockville 1 Yes 2 No Maryland Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20852 United States 6710 Tildenwood Lane death Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 is marked other then "naturel", or Iter 1 ∐Yes 2. If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 **X** No Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Law Attorney <del>%+</del> 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Martin Campbell Kellogg Emory ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8116 Rayburn Road, Bethesda, MD 20817 Kevin Dolan/ Grandson 20b. Place of Disposition (Name of Date 20c Location - City or Town State 20a. Method of Disposition Department of Himportant: If Ite ony injury or ot once. Georgetown University August Medical Center 2006 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11 Washington, D.C. 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, Inc. of Funeral Service Licensee P.O. Box 58007 Washington, D.C. 20037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscleratic cardiovascu yeans **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ng physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending p IE FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Dav in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death P.O. | the 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. pe 1 Yes 2 No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 1 ☐ Yes certificate Division of Vital After this certification Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death | Check only one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death Certification; 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medica (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Hagust Patricia 10m21 Name and address of person who completed cause of death (Item 23a) (Type, Print) ille Pike, G-100, Rockville, MD 20852

DHMH 17 Rev 1/2001

State Registrar AUG 1 5

31. Date filed (Month

32 Registrar's Signature

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75	Examin	er	4a. Facility Name (If not institution, MEMORIAL HOSPI)		mber)		4b. City, Town,		of Death		4c. County ALLE				
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	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					10	0d. Inside Cit	ty Limits	
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	th wit	Funeral Director	803 Hilltop Drive					21502	2		US	SA			
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land	uld be filed Mental Hygi irked other itic event, I	To Be	17. Father's Name (First, Middle, La William Bartle	•						. Bartle	Maiden Suman ett	1e)			
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Balt	permit. Pages Department of I Important: If it eny injury or o		21. Signature of Funeral Service Li	censee	11	22	2. Name and Add Scarpe 108 Vi	ress of Facili elli Fune rginia Av	ral Ho	ome, PA	rland MD	21502			
			21. Signature of Funeral Service Licensee  22. Name and Address of Facility Scarpelli Funeral Home, PA  108 Virginia Avenue: Cumberland, MD 21502  23a. Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, into the complete of the compl												
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			11/6				D591	.21			AUGUST 1	5 2	2006		
			30. Name and address of person w	no completed caus	se of death (Ite	m 23a) (Type,									
-			DR. TASNEEM MALIK		NT AVEN		TE 204	CUMBEI	RLAND	,MARYL	AND 215	02			
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	Examin	1 1	4a. Facility Name (If not institution, give street	at and number)		4b. City, Town, or	Location of Death	1	4c. County of Death	
		* *	Holy Cross				lver Spr:		Montge	
	Funeral		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, Day, Y	ear) 9. Birth	place (State or Foreign
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	land land		10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
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	3a o		4951 Blaine St	NE			20019		United :	States
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Iteme 23a or 28a-f ehow ant, the Macinal Familiaer must be puillfied at	Funeral	11 Marital Status 12.	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-	14. Race - Amen Black, White,	
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Division of Vital Records, P.O. Box	ith ce ttandi	an/l	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3	Ectopic pregnancy	1		23d. Date of delive	rery Day Year
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isi	Attending Physician: r death. ector: After this certifici by the funeral director, i	cat	3 Suicide 6 Could not be	28e. Place of Injury - At he			<b>X</b>	28f. Location (Stre	et and Number or Rui	ral Route Number,
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			1 Pratima	- Allon	K, M	D MD	4202	16	8/2/01	6
•	(5)		30. Name and address of person who comp	pleted cause of death (Iter	п 23а) (Туре,	Print)				
ار			Prat Patha	k, M.D. 15	00 For	est Glen	Road, Si	lver Spri	ng, MD 20	910
	s St	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signa	ature dia	Bi				
5.65	Regist	rar	AUG 1 4 2006	Many Je	19					

NATHANIEL ROBERT LANCASTER

O6-05892

Please Type or Print in Black Indelible Ink

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State of Maryland / Department of Health and Mental Hygiene

		l-For State Registrar Amend#20b_PerFHPCC8_14_06cr	Certificate o	f Death		Reg.	201	*				
Pħysicia edical Exami		1. Decedent's Name (First, Middle, Last)  NATHANIEL ROBERT LANCAS	TER			2. Date of Death Month E August 8, 20	Day Year DO6	3. Time of Death 2346 hrs				
1	e ·	4a Facility Name (if not institution, give street and number) 2806 Keith Street		4b. City, Town, o	or Location of Deat		4c. County of Dea					
Funeral Director		5. Social Security Number 6. Sex 7. Age (	In yrs last birthday)	If Under 1 Ye			(MM/DD/YYYY) 9. E	Birthplace (State or eign				
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id how any Ee.	_	10a. State 10b. County 10 P • G •	C. City, Town or Local TEMPLE H					10d. Inside City Limits  1 Yes 2 X No				
21215-0036 Mental Hygiene Marked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once.	Director	10e. Street and Number	10.11.20 1.	10f. Zip Code		ľ	Citizen of What Co	ountry?				
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sho and 7 is	To	19a Informant's Name/Relationship (Type, Print )  LISA LANCASTER / MOTHER	19b. Mailir 1937	Address (Street)	eet and Number or S DRIVE	Rural Route Number # 3 0 2	er, City or Town, Sta 3	ite, Zip Code)				
S - S - S - S - S - S - S - S - S - S -		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State	20b. Place of Dispo	isiti <b>on (Name o</b> f c	emetery,	Date 2	20c. Location - City	or Town, State				
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		4 Conation 5 Other Specify:  Signature of Funeral Service Lice Liee	MT. OLIV		ss of Facility TD	18-06	WASHING' FUNERAL	TON, DC				
ற் தித்திர் Physician	2	23a. Part I Enter the disease, or complications that paused th		722 N.	CAPITOL	ST.,N.	W WASH.	C 20001 Approximate Interval				
/Medical		failure. List only one cause on each line  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):										
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Division of Vital Records, Farl and Attending Physician: The law requires that death and birector: After this certificate has been signed in by the funeral director, page 2 should be	Completed					24a Was an autopsy perform	24b. Were	autopsy findings available completion of cause of				
tal Rec cian: The l certificate l ector, page		25. Was case referred to medical		26.Pla	ce of Death (Check	1 <b>Y</b> Yes 2						
F Vita Physicia r this ce al direct	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient					esidence 6 🗸 Oth	er: Scene				
on of tending Pl sath or: After the funera		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month Day Yea Aug 8, 2006	28b. Time of 2335 hrs	· · ·   ·	jury at Work? Yes 2 ✔ No	28d Describe hor Subject shot	w injury occurred					
Division pital or Attent ours after death teral Director: filled in by the	Certification:		ry - At home, farm, stre walk	eet, factory, office	building, etc.	or Town Sta		Rural Route Number, City				
Di To the Hospital Within 24 hours a To the Funeral completely filled	edical C	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examiner:				d due to the cause(	s) and manner as st	arted.				
To t with To t	Med	29b. Signature and title of certifier			nse number		29d Date signed (A					
		Pamele Brethay, mo	Ab /lane 22-1	0.0	C.M.E.		August 9, 2006					
2 (3)		30. Name an laddress of person who completed cause of deal Pamela Southall, MD Assistant Medical E	Examiner 111		Baltimore, MD	21201						
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's	Signature	1								

			1 - For Stata Registrar	State of M	larylan	d / Depa <i>Cer</i>	artmer <i>tifica</i>	nt of He te of D	ealth a Death	and M	lental Hy	gien2	006	5	27451
×		4	1. Decedent's Name (First, Middle, Last	')						-	2. Date of De		Vac		3. Time of Death
	Physici /Medi		Genevieve	Loug	hhead	1						11, Tay	2006 <sup>Yea</sup>	ır	1:47 P. M
	Examir		4a. Facility Name (If not institution, give					, Town, or		of Death			County of D		
		R.	Anne Arundel Med					apoli		0411			ne Arı		
**	Funeral Director			X 20 F 7. A	ge (In yrs. 1	Yrs.	Months	Days	If Under: Hours	Min.	8. Date of Bir (Month, Da June 14	y, Year)			ce (State or Foreign y) sylvania
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							100	d. Inside City Limits
	Mary!	ō	MD Anne Aru	ndel	Riva										1 ☐ Yes XXNo
	the the	rect	10e. Street and Number				10f. Zi	p Code				10a, Citiz	en of What	Countr	v?
	3a of	<u>-</u>	359 Berkshire Dri	ve				140				Unite	ed Sta	ates	5
9	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mudical Expenier, ust be notified at	/ Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent Armed Forces 1 ☐ Yes 300 If Yes, Give	?	1:	Vas Dece f Yes, spe l □ Yes	orty Cubar	spanic Origin, Mexican	gin? (Sp , Puerto	ecify Yes or No Rican, etc.)		4 Race - Al Black, W	hite, et	c.
003	ural',	d by	3 Widowed 4 Divorced	Year or Dates:											
Maryland 21215-0036	within 72 tens. than nati	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or	5+)	16a. Deced (Give life. L Homen	kind of w DO NOT (	ork done d use retired)	ition Juring most	t of work	ing		d of Busine Home	ss/Indu	stry
9	Hygid other	BeC	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	e (First, Middle	, Maiden S	іштате)		
lan	2 should be and Mental Is marked o	To B	Joseph Vlasic						Dani	ca (	maiden	not }	(nown	)	
ary	and A		19a. Informant's Name/Relationship (T	ype, Print)		19b. Mailin	g Addres	s (Street a	nd Numbe	r or Run	al Route Numb	er, City or	Town, State	e, Zip C	Code)
	of Health item 27 I		Robert Loughhead	(husban					Dr.	Riva	, Maryl				
Baltimore,	ges 1 I of H If ite		20a. Method of Disposition 1 ☐ Burial 2 ➡ Cremation 3 ☐ I	Removal from State	1 ~	lace of Dispo- emetery, cren	sition (Na natory or	me of other place	) Z	agus <sup>(</sup>	t 14,		ation - City		
Ē	tment tant:		4 □ Donation 25 □ Other (Specify,	)		ropolita		-	7	2006	5		dria,		
Bai	permit. Pages Department of th important: If ite eny injury or of		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or comp	Z MOC	982	42	Hudsc	n St.,	Suite	110	nt Funera , Annapol	is, Me			
8760,	Physician and // Medical Examiner polysician and publication of the project of th	dical Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		s a consequence a consequence	uence of):	T 10	⊂ B	LA	90 (	en c	AN	ER	(	nterval Between Onset and Death  Wille KS
.O. Box 68	death certif e attending id for use a	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic p Other (s	oregnancy pecify)				23	3d. Date of o Month	,	r ay Year
<u>a</u>	uires that signed by Id be deta	b	Part II. Other significant conditions co	ntributing to death				-	n in Part I.		23e. Did t				cause of death?
Vital Records,	The law requires that the sete hes been signed by the page 2 should be detache	Completed									24a. Was autor perfo		death	autops to comp ?	sy findings available pletion of cause of
ita	ysician: Th is certificete director, pag	BeC	25. Was case referred to medical examiner?					-	26. Place	of Deat	Check only o				
	Q 0	10	1 Yes 20No	Hospital: 1 Inpati	ent 2 🗆	ER/Outpatien			4 140	rsing Ho	me 5□Resi	dence 6	□Other (S	pecify)	
ion o	ling After fune		27. Mann : f Death 1	28a. Date of Inj (Month, Da	ury ay Yea <i>r)</i>	28b. Time of Injury	М	28c. Injury Work 1 🗌 Y	at ? ′es 2 □ ľ		28d. Describe	how injury	occurred		
Division of	i Die	Certification;	3 Suicide 6 Could not be determined	28e. Place of In building, e	ijury - At ho	ome, farm, stre	eet, facto	ry, office			28f. Location ( City or To	Street and wn, State)	Number or	Rurali	Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Phy (cneck only one) 2 Medical Exam	rsician: To the best mer: On the basis of and manner s	of examinat	wledge, death tion and/or inv	occurred restigation	at the time n, in my op	e, date an	d place, th occurr	and due to the ed at the time,	cause(s) a date and p	nd manner place, and d	as stat	ed. he cause(s)
	To th within To th	Me	29b. Signature and title of certifier	1			29	c. License	number			29d. Date	signed (Mo	onth, Di	By, Year)
)			· M/k	len	1 - N	OM	PH		03	83	28	81	141	0	0
	3		30. Name and address of person who c		death (Item	23a) (Type,	Print)				AYA	NNA	env	15	M D
	Sta Registi		31. Date filed (Month, Day, Year)  AUG 1 5 20	32 Regist	rar's Signa		AL.	- P			(3)	, , .		12	21401

State of Maryland / Department of Health and Mental Hygien 2006 27452 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Michael Joseph Long August 22, 2006 07:35 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Bayside Care Center Lexington Park If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, ) August 23, 9. Birthplace (State or Foreign **Funeral** 1XM 2□F 218-78-8630 Director District of Columbia 1959 46 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No St. Mary's Mechanicsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with USA 25826 South Sandgates Road 20659 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onen of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Itel
ary or other traumatic event, the Medical Examinal Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled 12 Disable 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Joan Alvey Thomas Lester Long, Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24461 Hollywood Road, Hollywood, Maryland 20636 Sandra Anne Eversberg / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State August permit. Page Department of Important: If any Injury or once. Charles Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 28, 2006 Leonardtown, Maryland 21. Signature of Funeral Service Licensee Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy or in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached the Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 1 Yes 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 1 □ Yes 2 Hospital: Other: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this nours after death.

neral Director: After this

filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 → Natural 2 □ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In the dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical nd manner stated. the 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 119917 123/06 30. Name a addr of son wh completed cause of death (Item 23a) (Type, Print) James C. Boya, M.D. Wildswood Shopping Center, California, Maryland 20619 31. Date filed (Month, Qay, Year) Registrar's Signature State Registrar

			1 - For State Registrar	State of Ma	ryland / De <i>C</i>	partmen ertificate	t of Hea e of De	ith and			2006	274	53
	Physici /Medic		1. Decedent's Name (First, Middle, Las Leon H. Mart	in					2. Date of De Month August	23 Day	2006	2:40	P M
	Examir	er	4a. Facility Name (If not institution, give  Bayside Care Cent  5. Social Security Number 6. Se	er	(In yrs. last birthd	Lexi	ington	Park Under 24 Hrs		St	County of Dea	¹s	Foreign
	Funeral Director		429-50-9116 Usual Residence of Decedent	XM 2□F	76 Yrs.	Months		ours Min		3y, Year) 3,193	30 Ar	rthplace (State or I country) kansas	
	Ba-f show	Director	Maryland St. Mary		Great							10d. Inside City 1 ☐ Yes 2	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or Items 23a or 28a-f show important: If term 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Expusion minatics indifficat at once.	Funeral Dire	10e. Street and Number 22051 Clipper Dr 11. Marital Status	12. Was Decedent E	ver in U.S. 1		0634	nic Origin? (S	Specify Yes or No to Rican, etc.)	Uni	ted St	ates	
9003	ural', or Ite	þ	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2	2 ₹ No S¢	ресту:	to Rican, etc.)		Black, Wh		
Baltimore, Maryland 21215-0036	within 72 l jiene. r then "net the Medice	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation (e completed) College (1-4or 5+	(G. life	cedent's Usua ive kind of wor a. DO NOT us ick Dri	rk done durin se retired)	g most of wo	rking		nd of Business	s/Industry rtation	
yland;	ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) Elbert Martin						me (First, Middle) e B. Eva	, Maiden		reacton	
e, Mar	1 and 2 she Health and em 27 ls m ther traum		19a. Informant's Name/Relationship (T)  Michele Brown / Da  20a. Method of Disposition	*		51 Clip	per D		ural Route Numb reat Mil Date	.1s,		nd 20634	
Itimor	nit. Pages artment of ortant: If It injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licens		сетеtегу, с Chapel I	rematory or ot Hill Me	therplace) em. Gai			0sc	eola,	Indiana	
Ba	Pen Ump eny		Kyle S. Simons	M01206		22955 H	lo11yw	ood Ro	ad, Leon	ardt		ryland 20	)650
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. A S P Due to (or as a Due to (or as a Due to (or as a								Approximate Interval Betwee Onset and De	ath
	cate be executed  physician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a Due to (or as a d.	consequence of):  consequence of):	scula		Accid	dent S			North s	
P.O. Box 68	The law requires that the death certificate be executed site has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death	3 □Ectopic pre 5 □ Other (spe				2	23d. Date of de Month	olivery Day Yea	ar
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions co		not resulting in the	underlying ca	use given in	Part I.		obacco u Yes 2		o the cause of dea	
al Reco	: The law recete has be page 2 sho	Completed							24a. Was autor perfo 1 🗆 Yes		24b. Were a prior to death?	utopsy findings ava completion of caus s 2 No	ailable se of
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	tlon: To Be	25. Was case referred to medical examiner?  1	lospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day)	28b. Time		104	Nursing H	ath <i>Check only</i> of lome 5 Resident 28d. Describe in	dence 6		ecify)	
Divis	ospital or Attend hours after death uneral Director; y filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	(Specify)				City or Tov	vn, State,		ural Route Numbe	r,
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	edlcal	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of ner: On the basis of e and manner state	xamination and/or	ath occurred a investigation,	at the time, da in my opinion	ate and place n, death occu	, and due to the irred at the time.	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)	
	To the company	¥	29b. Signature and title of certifier	Intell	al med		DOI				signed (Mon		
			30. Name a d address of person who ca Dr. Dhananjay Bh		ith (Item 23a) (Typ 35 Three		Road,	Holly	wood, Ma	ryla	nd 206:	36	
	Sta Registr	7.0	31. Date filed (Month Day Year) 20[	32. Registrar	s Signature	مكاوه							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			. For		aryland / Depa	artment of I	Health and M	ental Hvoi	ene	271 55
			1 - Stete Registrer		Cei	rtificate of	Death		g. No. 2006	27455
	Physici	an	Decedent's Name (First, Middle, Last	•				<ol><li>Date of Death Month</li></ol>	Day Year	3. Time of Death
	/Media	cal	Thelma Madeline  4a. Facility Name (If not institution, give		Construe	4h Cib. Taura	and another of Book	August	13 2006	
	Examir	ner	Westminster Nursir		Center		or Location of Death		4c. County of Dea	
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		roll thplace (State or Foreign
я	Director		219-20-4504	□M 2[X]F	93 Yrs.	Months Days	Hours Min,	July 8	Year) Co 1913	MD
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or La	cation				10d. Inside City Limits
	Maryll	5	MD Carro	N1 1	Keym					1 ☐ Yes 2 ☑ No
	ours after death with the Marylan rat', or iteme 23a or 28e-f ehow Examiner must be coulfied at	Funeral Director	10e. Street and Number	711	пеуш	10f. Zip Code		10	g. Citizen of What Co	ountry?
	h with		5800 Middleburg	Road			21757		USA	,
	deat	ner	11. Marital Status	12. Was Decedent I	ever in U.S. 13.		Hispanic Origin? (Spe pan, Mexican, Puerto	cify Yes or No-	14. Race - Ame	
36	or its		1 Never Married 2 Married	1 Yes 2 X	lo	1 □ Yes 2 □ <b>3</b> (No		nican, etc.)	Black, Whit	e, etc. hite
8	72 hours after death with the Maryland "natural", or iteme 23a or 28e-f ehow digal Examiner must be redified at	d by	3X Widowed 4 □ Divorced	Year or Dates:						
15	⊆ 34	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of working	ng 1	6b. Kind of Business.	Industry
212	filed within Hygiene. ther then *	mo	Elementary/Secondary (0-12)	College (1-4or 5	+)	Homemak	•		Own Home	
ğ	Hyge Hyg	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M.		
/lar		To E	Guy Flickinger				Mary W	ætzel		
Maryland 21215-0036	and and is my		19a. Informant's Name/Relationship (T)	vpe, Print)	19b. Mailir	g Address (Street	and Number or Rura	l Route Number,	City or Town, State.	Zip Code)
-	E 2 2		Paul Flickinger/n	ephew	2741	Salem B	ottom Road	Westing	nster, MD	21157
Baltimore,	ges 1 t of H if ite		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. Place of Dispo cemetery, cren			37/2006 <sup>20</sup>	Oc. Location - City or	Town, State
Ë	t. Partmen		4 □Donation 5 □Other (Specify)			Branch C			Westminst	er, MD
Bal	permit. Pages 1 Department of He important: If iten eny injury or oth		21. Signature of F ral Service Licens		₽ <u>22</u>	Name and Addre	neral Home	and Cha	pel, P.A.	
			23a Part1. Enter the disease, or compl	ications that caused	4	12 Washi	ngton Road	Westmi	nster. MD	21157
			shock or heart failure. List only of	ne cause on each lin	θ.					Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)		NOEST	TUE !	TEART	FAILL	IRE	
П	Examiner			Due to (or as a	consequence of):					
		je.	Sequentially list conditions, if any, reading to immediate	b. Due to (or as a	r consequence of):					
	ite be executed ysicien and he burial-transit	Examin	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
,092	e exe ien ar urial-t		resulting in death) Last	Due to (or as a	consequence of):					
876	ate b hysic the bu	licai		d						21.9355 - A. V. 1.73555
x 68	death certificate t e attending physic of for use as the E	by Physician/Medi	IF FEMALE:	120 16				220	100000	- 1
Box	attendation for us	lan	in the past 12 months?	3c. If yes, outcome of 1☐Live birth : 4☐Pregnant at	2 Fetal death 3	Ectopic pregnancy	у		23d. Date of del Month	ivery Day Year
o.	~ w ×	lysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	mile or death 3	Other (specify) _				
Ω,	law requires thet the de as been signed by the a 2 should be detached f	y Pt	Part II. Other significant conditions cor	ntributing to death bu	t not resulting in the un	iderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	quires n sign							1 🗆 Yes	20No 3 Pr	obably 4 Unknown
00	aw require s been sig	Completed						24a. Was an	24b. Were au	topsy findings available
R	0 - 2	E						autopsy performe	death?	topsy findings available completion of cause of
ita	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of Death	1 Yes 26		2 No
<u>&gt;</u>	Physician: r this certific ral director,	10	1 Yes 2 No	łospital: 1 ☐ Inpatier	nt 2 ER/Outpatient	3 DOA Oth	ner: 48 Nursing Hom	ne 5 Residen	ce 6 □Other (Spec	cify)
Division of Vital Records,	ing P		27. Manner of Death  1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day		28c. Injur Wor	y at 2 rk?	8d. Describe how	injury occurred	
Sic	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	20 81 (1)			Yes 2 □ No			
Σ	after after Direction by	Certification;	4 Homicide determined	building, etc.	ry - At home, farm, stre (Specify)	eet, factory, office	2	8f. Location (Stre City or Town,	et and Number or Ru State)	rai Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death within 24 hours after death completely filled in by the funeral director, completely filled in by the funeral director.		29a. Certifier 1 Certifying Phys	sicien: To the best o	f my knowledge, death	occurred at the tir	me, date and place a	nd due to the carr	Se(s) and manner an	stated
	ne Ho ne Fu	Medical	(Check only 2 Medical Exemit	ner: On the basis of and manner stat	examination and/or inv	estigation, in my o	pinion, death occurre	d at the time, date	and place, and due	to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and little of certifier	-00	M.D.	29c. Licens	e number	290	I. Date signed (Month	o. Day, Year)
	111.		Y			DO	59552		8/14/06	
	MAS		30. Name and address of person who co			·				
			C-OURISHARKAR			WA PUO	LE WEST	MINSTER	MD D	115-7
	Sta Registra		31. Date filed (Month, Day, Year) AUG 1 5 2	1006 Paristra	r's Signature	1				
	negistii	-1	700 1 0 7	UUU JACK	IN ST	oule				

	1 - For State Registrar	State of Maryla	nd / Depa	artment of I	Health and I <i>Death</i>	Mental Hyو ا	giene 200	6 27456
Physician	Decedent's Name (First, Middle, Last)      Decedent's Name (First, Middle, Last)      Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Ye	3. Time of Death
/Medical Examiner	Ruth B. Mihall 4a. Facility Name (If not institution, give sti	·			or Location of Deati		4c. County of I	Death
Funeral Director	Homewood Retirement Ce 5. Social Security Number 6. Sex 1 1 1		s. last birthday) Yrs.	If Under 1 Year Months Days	rederick If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day	n v, Year) 9.	derick Birthplace (State or Foreig Country) est Virginia
yland	Usual Residence of Decedent  10a. State 10b. County	10c. 0	City, Town or Lo	cation				10d. Inside City Limits
death with the Maryland ms 23s or 28s-f show rount to nullited at	Maryland Montg  10e. Street and Number	omery	Silver Sp	ring			10g. Citizen of Wha	1 ☐ Yes 2 No
23e or	1607 Cody Drive				20902		US	Ą
j 2 3 j	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Nas Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - /	American Indian, Vhite, etc.
"nat	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)		(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of wor	king	16b. Kind of Busine	ess/Industry
filed withii Hygiene. ther than out, Ire M		2	Admir	istrative	Assistant	]	Defense Cont	tractor
be filed stal Hygin of other event, II Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Sumame)	
should be not Mental marked o	Otis Baldwin				Gertrude			
12 sho	19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailir	g Address (Street	and Number or Ru	ral Route Numbe	r, City or Town, Sta	te, Zip Code)
ges 1 an t of Heal If item 2 or other	John B. Mihall/ Son  20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ Rei  4 □ Donation 5 □ Other (Specify)	moval from State	Place of Dispo	ody Drive, sition (Name of natory or other pla ven Cemete	rv	Date st 16,	20c. Location - City	
permit. Pa Departmen Important: eny injury	21. Signature of Funeral Service Licenses				200 Signification Fune Styling Fune	eral Home 1	Silver Sprin Inc. Dring, MD 20	
physician and ithe burial-transit and dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a conse	equence of):	rten	disea	16		Onset and Death
death certifi e attending id for use as ician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	t. If yes, outcome of pregr 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnanc Other (specify)	,		23d. Date of Month	delivery Day Year
requires that the een signed by the hould be detache sted by Physical Physi	Part II. Other significant conditions control  A. FIB, SEPURCO	ibuting to death but not re		, , ,				e to the cause of death?  Probably 4 Funknow
has b		FR-MR-T				24a. Was a autops perfor	y prior	autopsy findings availabl to completion of cause of 1? Yes 2 No
ysicien: Th is certificate director, pag	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only or		22.10
ling Phys	1 Yes 2 No Ho:  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	spital: 1 □ Inpatient 2 [ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injui Wor	y at		ence 6 Dother (Sow injury occurred	Specify)
tal or Attending Prs after death.  sol Director: After ted in by the funeration by the funeration;  Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stre ify)	eet, factory, office		28f. Location (Si City or Town	treet and Number or n, State)	r Rural Route Number,
he Hospi n 24 hou he Funer pletely fill edical	29a. Certifier 1 ☐ Certifying Physic (Check only one) 1 ☐ Medical Examine	r: On the best of my kr r: On the basis of examin and manner stated.	nowledge, death lation and/or inv	occurred at the tirestigation, in my o	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
To the within To the comp	29b. Signature and title of certifier	20		29c. Licens	e number L1936	2	9d. Date signed (M	
8	30. Name and address of person who com  A. DONELSON	pleted cause of death (Ite	m 23a) (Type, T#m4	Print\		FRE DE	RICE. M	10 21702
State Registrar	31. Date filed (Month, Day, Year) AUG 1 5 200	32. egistrar's Sign	B. A	arti	,			

			1 - For State Registrar		Stat	e of M	arylar	nd / Depa <i>Cei</i>	artme <i>tifica</i>	ent of F	lealth a Death	and M	ental Hy	/gien Reg. Ne		06	27	457
	Physici /Medi		<ol> <li>Decedent's Name</li> <li>William John</li> </ol>		Last)								2. Date of Domeston	Dá	₃y 2006	Year	3. Time o	f Death p M
H	Examir		4a. Fecility Name (If I						4b. Cit		Location o	of Death	August		c. County			
1	Funeral Director		5. Social Security Nur 213-40-9058	mber 6	6. Sex	7. Ag	ge (In yrs. 63	last birthday) Yrs.	If Und Month	er 1 Year		Min.	8. Date of Bi (Month, D ct. 26,	rth ay, Year 1942	)	9. Birthi	omery place (State ntry) sylvania	
	Maryland -f show	tor	Usual Residence of D 10a. State Maryland	Decedent 10b. County	Montgo	mors 7	10c. Ci	ity, Town or Lo	cation Ckvi]	10						1	l0d. Inside C	ity Limits
	h with the 23a or 28a at be notifi	Direc	10e. Street and Number 5904 Coral			mery				ip Code	351			10g. Ci	itizen of V		ntry?	
5-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show clical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4		d 1 []	Decedent ed Forces? Yes 2 <b>X</b> I s, Give r or Dates:	•	'	Yes, sp	cedent of Hoecify Cuba 2 121 No	ispanic Origin, Mexican	gin? (Spe	cify Yes or N Rican, etc.)	0-	Blac	e - Americ k, White, : Whi		
0-61212	within 72 iene. r than "na the Woold	Completed		15. Decedent's y o <i>nly highest</i> dary (0-12)	grade comple	<i>eted)</i> ege (1-4or 5	5+)	16a. Deced (Give life. L	kind of v OO NOT	vork done i use retired	during most f)	t of workin	ng		Kind of Bu			
yland	should be filed nd Mental Hygi marked other imatic event, II	To Be C	17. Father's Name (F William He	enry McCa	abe								(First, Middle ma Marie	, Maidei	n Surnam			
ге, маг	1 and 2 Health a am 27 is		19a. Informant's Nam  Matthew J.  20a. Method of Dispo	McCabe/		")	20b. i	FO12 To	thill sition (N	Drive	Olne	y, Ma	i Route Numb ryland 2 ate	0632			Code)	
aitimor	tment tant: If		1 ☐ Burial 2√☐ 4 ☐ Donation 5 21. Signature of Fund	Other (Spe	cify)	from State		cemetery, cren tropolita 22	n Cr	enator	y ss of Facility	August 2000 y	5	Alexa	endria			
ñ	permii Depar Impor any in		23a Part1. Enter the shock, or heart	disease, or co	7	that caused	the deat	500	) Uni	versit	y Blvd	, W, S	al Home Silver S	princ	g,MD 2	0901	Approximat	ie
	Physician /Medical		Immediate Cause (Fi disease or condition resulting in death)		_ a	e to (or as	te i	hem or 1	ng	e	-						Onset and	
	Examiner	iner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in	nediate ving	b	5 gu a e to or as			4	carc	eno.n	<u> </u>					nenth	5
8/00,	icate be executed physicien and s the burial-transit	edicai Examiner	that initiated events resulting in death) La		c. Du	e to (or as	a conseq	quence of):										
o xog .	death certii e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 □ 1 9 □ Unknown	onths?	1 □ L 4 □ F	s, outcome ive birth Pregnant at Jnknown	2 Feta	al death 3	Ectopic Other (	pregnancy specify)					23d. Date Mor	e of delive	*	Year
cords, P.	The law requires that the the has been signed by th vage 2 should be detached.	ρ	Part II. Other signific	ant condition	s contributing	to death b	ut not res	sulting in the ur	derlying	cause give	en in Part I.			obacco Yes 2		ibute to th	ne cause of c	leath? Jnknown
iiai neco	i: The law re icete has be r, page 2 sho	Completed				15							24a. Was auto perfo 1 \( \text{Yes} \)		d	Vere autorior to coreath?	psy findings apletion of c	available ause of
1 × 1	hyslcier his certif I directo	To Be	25. Was case referred examiner?  1 \( \text{Yes} \) 2 \( \text{No.} \)		Hospital:	1 🗆 Inpatie	ent 🎻	ER/Outpatient	3 🗆 🗆	Othe Othe	00		Check only		6 □Othe	er (Specify	<i>(</i> )	
VISION OI	anding Peath. or: After title funera	Certification:	Accident	5 Pending investigat	on (	Date of Injui Month, Day		28b. Time of Injury	М	28c. Injury Work 1 🗌 `	at i? ∕es 2 □ N		8d. Describe	how inju	ry occurre	ed		
20	To the Hospital or Attanding Physicien: The law within 24 Hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		3 ☐ Suicide 4 ☐ Homicide	determine	ed 286.	ouilding, etc	c. (Specif						8f. Location ( City or To	wn, State	∍)			ber,
	the Hosp in 24 ho the Func ipletely f	Medical	29a. Certifier 1 (Check only 2/ one)	☐ Medical Ex	aminer: On t	o the best of he basis of manner sta	examina	owledge, death tion and/or inv	occurre estigatio	d at the time in, in my op	e, date and pinion, deat	d place, a h occurre	nd due to the d at the time.	cause(s date and	) and mar d place, a	nner as st nd due to	ated. the cause(s	)
1	To To Com	2	29b. Signature and hit	le of certifier	San	de	N	n	25	9c. License	number 992	1			-	*.	Day, Year) 2006	
	5		30. Name and address Aaron Snyo	s of person wh der, M.D	o completed • 9901	cause of de Medica	eath (Iten al Cen	n 23a) (Type, f nter Driv	Print) e, Ro	ckvil	le, Mar	yland	20850					
系	Sta Registr		31. Date filed (Month.	Day, Year)	2006	Registra	ar's Signa	ature A	N. J									

State of Maryland / Department of Health and Mental Hygiene 2006Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 11:30 P M - avaida 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner linton Georges Haspital Marylana rince outhern If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-18- 191 6. Sex Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. 1 ☐ M 2 🗗 🕇 86 578-38-3422 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28s-f ehov other traumatic event, the Medical Examiner must be notified at 1 - Yes 2 □ No Completed by Funeral Director lemple VINCE permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Heelth and Mental Hygiene. Important: If Item 27 Ie merked other than "natural niury or other traumatic." 10f. Zip Code 10g. Citizen of What Country? USA 3408 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 Nidowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clovernment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Addr ss (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) race Daugh ker Sandra Prown 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses D.C. 20003 formas Ave, SE Washing ton 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Attending Physician: The law requires that the death certificate be executed sete has been signed by the attending physicien and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Medical Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use copyribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificete 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 V Inpatient 2 ER/Outpatient 3□ DОА hours after death. inerel Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Man or of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signatule and title of certifier 29d. Date signed (Month, Day, Year) DUO63690 and address of person who completed cause of death (Item 23a) (Type, Print) urate Rend Stc. 208-6 31. Date filed (Month, Day, Year) State AUG 1 4 2008 Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		Certifi	icate of I	Death		R	eg. No	UU	2140
Physici		1. Decedent's Name (First, Midd	le,Last)				-	Date of Dea     Month	ath Day Yea		Time of Death
Medical Exam	iner	Franklin Delon	o Pilkerton					August 17	7, 2006	ar	1948 hrs
		4a. Facility Name (if not institution			4b	. City, Town, or L	ocation of Dea	th	4c. County		
		20654 Point Look Out	Road			Great Mills			St. Mary	'S	
Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. last b	oirthday)	If Under 1 Year	If Under 24H		rth(MM/DD/YYYY	9 Birthp Foreign	lace (State or
Director		214-30-0334	1 X M 2 F	73	Yrs	Months Days	Hours M		23, 1933	Coun	<sup>try)</sup> Maryland
		Usual Residence of Decedent						1		J	
any		10a. State 10b County	·	10c. City, Tov	wn or Location	n				1	0d. Inside City Limits
nd show	ž	Maryland St. M	arvs	Great	Mills					1	Yes 2 X No
Maryland 28a-f show d at once.	ecto	10e. Street and Number		01000		10f. Zip Code		1	0g Citizen of Wh	nat Country	/?
ith the Maryland 23a or 28a-f sho notified at once.	Director	20654 Pt. Look	out Dood			20634		ļ	TICA		
with 1		11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was	Decedent of Hisp	anic Origin? (	Specify Yes or No	USA 14 Race	- America	n Indian, Black,
eath item	Funera	1 Never Married 2 M	arried Armed Forces?	X No	If Yes	s, specify Cuban,	Mexican, Puer	to Rican, etc.)	White	e, etc.	
fter d I", or		3 Widowed 4 X Div	orced If Yes, Give Year	ZX NO	1 Y	es 2 X No	specify:		Specify:	Whit	0
urs a Itura	d by	15. Decedent's Education (Spe	or Dates: cify only highest grade com	pleted) 16	a Decedent's	Usual Occupatio	n (Give kind o		16b. Kind of Bu		
5 72 hc n "na al Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	i+)	during mos	t of working life. [	DO NOT use re	etired)			
036 ithin ne.	ldu	12			Insura	nce Sale	sman		Insura	ance	
5-0 ed w tygie other	S	17 Father's Name (First, Middle,	Last)					ne (First, Middle, I	Maiden Surname	)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	John Henry Pi	lkerton				Mary	Lillian	Quade		
ould on Me	10	19a. Informant's Name/Relations	hip (Type, Print )		19b. Mailing A	Address (Street	and Number of	Rural Route Nur	nber, City or Tow	n, State, Z	ip Code)
MD 12 sh th an 127 i		Anna Mae Dean/ Da	ughter		1845.	3 Windmill	Point R	oad, Dray	den, Maryl	and 20	630
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-15he injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition			e of Disposition	on (Name of ceme	etery,	Date	20c. Location -	City or To	wn, State
MOI ages ent of nt: 1		1 X Burial 2 Cremation 4 Donation 5 Other Sp				morial Gar		gust 24, 2006	Croat M	1110	Manyal and
ultir nit F artme oortai		21. Signature of Funeral Service		LEVELS	22. Na	me and Address o	of Facility			IIIS,	Maryland
ini III De B		michael Kever	Hardini S	1	Mat 415	tingley-Ga 90 Fenwick	rdiner F	uneral Hon	ne, P.A. own, Maryl	and 20	650
Physician		23a. Part I. Enter the disease, or	complications that cau led	the death. Do	not enter the	mode of dying, si	uch as cardiac	or respiratory arr	est, shock, or hea	art T	Approximate Interval
/Medical		failure. List only one cause  Immediate Cause (Final disease	0 - 1 - 1 0 - 1 -	t Wound t	o the Hear	4					Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a conse			4				_	
		Sequentially list conditions,	b								
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of):							
7	ami	(Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a conse	quence of):	_					-	
uted Id ansit		events resulting in death) Last	d.	. ,							
<b>Records, P.O. Box 68760,</b> The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	an/Medical	UNPENDED	AMENDED					·			
60, ate be hysic e bur	Med	IF FEMALE:	23c. If yes, outcom	e of pregnance	cv				23d. Date of	delivery	
68760, ertificate b ding physic	an/I	23b. Was decedent pregnant in the past 12 months?	ne 1 Live birth	, , ,		death 3	Ectopic pregr	nancy	Month	Day	Year
ox 6	Sicie		(DOWD	time of death	5 Othe	r (Specify)					
, P.O. Box 6 res that the death ce signed by the attend be detached for use	Physicia		9Onknown				_				
P.O.	by F	Part II. Other significant condit	ions contributing to death	but not resulf	ting in the und	derlying cause giv	en in Part I		bacco use contri		
S, F uires n sign d be	pe					_		17		Probab	ly 4 Unknown
ords  * requi s been should	Completed							24a Was autop			sy findings available in injection of cause of
Recol The law icate has	E							perfo	rmed? d	eath?	2
		25. Was case referred to medica	1			26 Place o	of Death (Chec				2
Division of Vital Records, tal or Attending Physician: The law requirers after death all Director: After this certificate has been siled in by the funeral director, page 2 should be	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2 ER	/Outpatient		thor =		Residence 6	Other: S	cene
n of Vi ding Physi After this funeral dir		27. Manner of Death	28a. Date of Injur	y 28t	b. Time of Inju	ary 28c. Injury	at Work?		how injury occurre		
ion tendin eath the ful	tio	1 Natural 5 Pend			OUND:	1 Ye	es 2 🗸 No	Subject sho	t self		
riSic r Atte er de recto	ica		stigation Aug 17, 2006 28e. Place of Inj		42 hrs , farm, street,	factory, office but	ilding, etc.	28f. Location (S	Street and Number	er or Rural	Route Number, City
Divis spital or At tours after d neral Direct filled in by	Certification:		d not be rmined (Specify) Sing	ale Family			3.	or Town, S			
Hospi 4 hou funer ely fil		29a. Certifier	hysician: To the best of my		death occurre	d at the time date	and place an				
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi completely filled in by the funeral director,	Medical	one) 2 Medical Exa	miner: On the basis of exam	nination and/o	or investigation	n, in my opinion, o	death occurred	at the time, date	and place, and d	ue to the c	ause(s)
To Wij	Me	29b. Signature and title of certifie	and manner stated.			29c. License	number	_	29d. Date signe	ed (Month	Day, Year)
						O.C.M	l.E.		August 18,		. ,
		30. Name and address of person	with completed course of the	ath (Itom 22							
		·	Assistant Medical Ex			Street. Baltin	nore. MD 2	1201			
	tate										
	trar	31. Date Aled Googh, 2 ay 2 oak	Allen A	A							

			1 - For State Registrar	ite of Maryland		artment of H tificate of L		ental Hygie Rag.	711115	27460
			1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici /Medic		JANICE E. PI	NENEY				Month /	Day Year 4 2006	4:45 Am
	Examin		4a. Facility Name (If not institution, give street a	·			Location of Death		4c. County of Death	
			Bradford Oaks Nurs			Clinto			Prince (	
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2	7. Age (In yrs. la	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye 5 / 31 / 19	9. Birth Cou 35 Wash	place (State or Foreign intry) DC nington
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mary -f sh	tor	Maryland Prince G	George Br	andv	wine				1X Yes 2 ☐ No
	th the	lrec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	intry?
	ath will	Funeral Director	14216 South Spring	field Rd		20613		ט	SA	
	er deg	nue	Am	is Decedent Ever in U.S ned Forces?		Was Decedent of Hi f Yes, specify Cubai	spanic Origin? (Spe n, Mexican, Puerto f	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
36	filed within 72 hours after death with the Maryland Hygiene. After then "neturel", or Items 23e or 28e-f show ent, The Madical Examiner must be notified at	by F	If Y	]Yes 2[2]No ′es, Give ar or Dates:	1	l □ Yes 2√□ No	Specify:		Specify: B1	ack
21215-0036	2 hou	ted	15. Decedent's Education		16a. Deced	lent's Usual Occupa	tion	166	o. Kind of Business/Ir	ndustry
215	thin 7 e.	Completed	(Specify only highest grade comp Elementary/Secondary (0-12) Co	llege (1-4or 5+)	(Give life. L	kind of work done d DO NOT use retired;	uring most of workir	ng		
	ed wi ygien ver th	Con	12		He	omemaker			Domesti	С
and	ntal H ed otl	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Mai	•	
Maryland	hould id Me mark matic	L 2	Library  19a. Informant's Name/Relationship (Type, Pri		roug		Marie	I Pouto Number, Ci	JO ity or Town, State, Zi,	hnson
₹	nd 2 sulth an lith an 27 is r treu		Alfred L.Pinkney/H						2	N612
	s 1 ar f Hea item		20a. Method of Disposition	20b. Pla	ice of Dispos	sition (Name of natory or other place		ate 200	Brandyw Location · City or T	own, State
E	Page nent c int: If iry or		1 ☐ Burial 2X Cremation 3 ☐ Remova  '4 ☐ Donation 5 ☐ Other (Specify)	ii irom State	ropo	litan Cr	8/16	/06 A	lexandri	a Va
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumatic event, the Madical Examiliner must be notified at once.		21. Signature of Funeral Service Licensea	7	22	. Name and Addres	s of Facility 206	05 Aguas	sco Road	u , vu.
_	20 E # 9		July 6	191	A(	Jams Ful.	lerar no	ne, Aqua:	sco mary	land 20608
Ц			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause							Approximate Interval Between Onset and Death
8	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	inkrioscher	itic 1	en.phenl	Vascular	vische		
Н	Examiner			Oue to (or as a consequence	nce of):					
		er	Sequentially list conditions, if any, leaving to immediate	ua to (or as a conseque	once of):	Υ				
	cuted ad ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ó,	e exerian ar urial-t	EX	resulting in death) Last	due to (or as a conseque	ence of):			-		
68760,	icate be executed physician and s the burial-transit	edical	d							
_			IF FEMALE: 23c If yo	es, outcome of pregnance	ov					
Вох	The law requires that the death certifute has been signed by the attending the has been signed by the attending bage 2 should be detached for use a	Physician/M	in the past 12 months?	ILive birth 2 Fetal d Pregnant at time of dea	leath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
P.O.	the d by the ached	hysi	9 Unknown	Unknown		- (aposity)				
	s that gned t	by P	Part II. Other significant conditions contribution	g to death but not result	ing in the un	derlying cause give	n in Part I.	23e. Did tobaco	co use contribute to t	he cause of death?
ğ	w require been sig should b							1 🗌 Yes	2 No 3 Prot	pably 4 ∐Unknown
Division of Vital Records,	e law re has be je 2 sh	Completed						24a. Was an autopsy	24b. Were auto	ppsy findings available
<u>~</u>	ysicien: The Is certificate ha	Con						performed 1  Yes 2  X	? death? No 1 \(\sum Yes\)	2 □ No
Zii	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			Otho	26. Place of Death			
o	Phys	To	1 162 5 100	1   Inpatient 2   El	R/Outpatient	3 □ DOA Other	4 X Mursing Hom	e 5 Residence	6 Other (Special	y)
on	th. : Afte	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work'	? es 2 □ No	33. 233(123 1.314 11	nary securios	
N	Atter	iffice	a □ Could not be	Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office	2	Bf. Location (Street	and Number or Rura	il Route Number,
	rs after or sell or se	Certification:	Tomodo	building, etc. (Specily)				City or Town, St	210)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	edical	29a. Certifier (Check only 2 Medical Examiner: On	To the best of my knowl the basis of examination	edge, death n and/or inv	occurred at the time	e, date and place, a	nd due to the cause d at the time, date	e(s) and manner as s	tated.
	the thin 2 the control the con	Med	29b. Signature and title of gertifie	d manner stated.		29c. License	number	29d	Date signed (Month,	Day Yearl
	i i i		1 With ar	Lenn		DR	C206	٨.,	a lul-	Day, reary
(			30. Name and address of person who complete	To the best of my knowl in the basis of examination discontinuous discon	23a) (Type, F	Print)		Ro	Yust 14,	26
	\$3		WILLIAMTTANNWIM	11701 Li	Vinge	ton Road	, Fort u	JASH ing to	m. mn	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	re					
ke	Registr	ar	AUG 1 6 2006	person s	J 19	and a				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006State Registra AMEND#8, perFH, 8/15/06, DPS, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST 9, 2006 9:00 P M MARLENE S. QUADE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CASEY HOUSE MONTGOMERY HOSPICE ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Date of Birth (Month, Day, Year 1/7/<del>1957</del> 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ √F 220-54-1473 55 Yrs. DC Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Iteme 23s or 28s-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No MONTGOMERY MARYLAND SILVER SPRING Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15102 CIDER WOOD COURT death 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: CAUCASIAN 3 ☐ Widowed 4 █ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene CONTRACT NEGOTIATOR DEPARTMENT OF COMMERCE or other traumatic event, permit. Peges 1 and 2 should be file.
Department of Heelth and Mental Hy important: If Item 27 is marked other any injury or other traumette. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDWARD SCHRIER CORINNE D. RUBIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CORINNE D. SCHRIER - MOTHER 7892 MONTECITO PLACE; DELRAY BEACH FL 33446 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MT. LEBANON CEMETERY 8/13/2006 ADELPHI. MD d 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME Myclin V. Wes 11800 NEW HAMPSHIRE AVE; SILVER SPRING MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician BREAST CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physicien Physician/Medical the as attending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery The law requires that the death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 \( \tilde{\t 1 ☐ Yes Physician: To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE 2 🖺 No 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Attending 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Funerel Dire To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Cimitia M Milliam. H0058032 8/10/2006 10

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CYNTHIA D. WILLIAMS, D.O.

31. Date filed (Month, Day, Year) **AUG 1 5** 2006

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State of Maryland	Department of He	ealth and Mental	Hygiene	2006	

		_	1 - For State Registrer	State of Marylar			nt of He te of D			Reg. No		6 2/46
Е	Physici	an	Decedent's Name (First, Middle, Last)     Month Day Year						3. Time of Death			
	/Medic		Ch1 C1 D1 11 2000							5:45am <sup>M</sup>		
1	Examin	er	4a. Fecility Name (If not institution, give					_ocation of Dea	ıth	1	County of Dea	
			Wilson Health Care 5. Social Security Number 6. Se		lant hirthdayl		thersl	ourg	s. 8. Date of Bi	Mo	#	
М	Funeral		15	IM 2CIE		Months	Days	Hours Mir	. (Month, D	ay, Year)	Co	thplace (State or Foreign
	Director		213-14-5126 Usuel Residence of Decedent	9	0				Apr 28	, 19	10   Ge	orgia
	/land	10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits		
	Man	to	Maryland Montgome	rv Ga	ithers	burg						1 A Yes 2 □ No
	n the	Director	10e. Street and Number				ip Code			10g. Cit	izen of What Co	ountry?
	th wit	aiD	415 Russell Avenue	#915		20	877			Unit	ed Stat	es
	dee T	by Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Dec	edent of His	panic Origin? (	Specify Yes or Norto Rican, etc.)	0-	14. Race - Ame Black, Whit	
9	or th	F	1 Never Married 2 Married	1 ☐ Yes 2 ☒ No If Yes, Give		1 ☐ Yes		Specify:	, 0.0.,		Specify:	10, 010.
21215-0036	within 72 hours after deeth with the Maryland ene. then "neturel", or iteme 23a or 28a-f show the Madical Exemiter mastice notified at	d b	3 Widowed 4 Divorced	Year or Dates:							Wh	nite
2	nst	Completed	15. Decedent's Edu (Specify only highest grad		(Give	kind of w	ual Occupat ork done du use retired)	ion iring most of w	orking	16b. K	ind of Business	Andustry
2	then in	Ę	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		emist	-			Fod	lomal Co	vernment
2	Hygie ther int.	ပိ	17. Father's Name (First, Middle, Last)	JT	CITE	:IIII S C		18. Mother's Na	ame (First, Middle			Veriment
au	d be ontal	9 Be	James Glenn Rainey	7			1		Weddingt			
Maryland	mari mati	ဥ	19a. Informant's Name/Relationship (T)		19b. Mailie	na Addre			Rural Route Numb		or Town, State.	Zip Code)
S	Ith ar		Ethel Cann Rainey	(spouse)					15, Gai			
ē,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturst", or Itema 23a or 28a-1 show any injury or other traumatic svant, the Medical Exactinating the notified an once.		20a. Method of Disposition		Place of Dispo				Date		ocation - City or	
altimore,	Page ento		1 ☐ Burial 2 ☒ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval nom state				tory 8/	11/06	Δ1ρν	andria.	, Virginia
≣	artin el		21. Signature of Funeral Service Licens		22	2. Name :	and Address	of Facility	eVol Fur Drive			VIIginia
ä	e de la companya de l		Coberts A	Jelot 1	10	) Eas	t Dee	r Park g, MD 2	Drive 0877			
	Physician /Medical		23a. Part Friter the distante, or complete the distante, or complete the distante of the dista	ications mat caused the dea						rrest,		Approximate Interval Between
		)	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final									Onset and Death Years
			disease or condition resulting in death)	4	Cerebro-Vascular Disease  Due to (or as a consequence of):							ieals
	Examiner			b. Carotid Atherosclerosis  Due to (or as a consequence of):								Years
	icate be executed physicien and s the burial-transit	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
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Ö,	e exe	Ä	resulting in death) Last	Due to (or as a consec	quence of);							
8760,	icate be executed physicien and the burial-transit	edicai		d								
9	entific ling p		IF FEMALE:									
Box	ath co	lan	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 Live birth 2 ☐ Fet	al death 3 □		pregnancy				23d. Date of de Month	livery Day Year
0.	the e	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant all time of a 9 ☐ Unknown	death 5L	Other (	specify)					
	The law requires that the death certit ete hes been signed by the ettending page 2 should be detached for use a		Part II. Other significant conditions co	ntributing to death but not re-	sulting in the u	nderlyina	cause giver	in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
ds,	sign d be	d by	Hypertension	•		, ,	•		1 🗆	Yes 2	⊠No 3⊟Pi	robably 4 Unknown
ö	w requir been si should	Completed							24a. Was		24h Wasa a	utopsy findings available
Ä	hes ge 2	Ē							auto		prior to death?	completion of cause of
ā	n: Ti ficete or, pa	ပိ	25. Was case referred to medical					00.01	1 ☐ Yes	2 <b>%</b> No	1 ☐ Yes	2 □ No
5	Attending Physician: r death. sctor: After this certifice by the funeral director, I	00	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	TER/Outpatier	nt 3 🗆 🖸	Other		eath (Check only Home 5 Res		€ □Other (See	on field
ō	a Phy ar this aral o	<u>2</u>	27. Manner of Death	28a. Date of Injury	28b. Time of		28c. Injury		28d. Describe			cny)
<u></u>	th. :: Afte	at lo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation			Work? M 1 ☐ Yes 2 ☐ No						
Division of Vital Records,	il or Attend after death I Director: , d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h	nome, farm, str	eet, facto	ry, office		28f. Location	Street an	d Number or R	ural Route Number,
	s afte	Cert	- Communication	building, etc. (Speci	· <b>y</b> )				Ony or re	wii, State	,	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificete he completely filled in by the funeral director, page		29a. Certifier 1 ☑ Certifying Phy	sician: To the best of my kn	owledge, deatl	h occurre	d at the time	e, date and place	e, and due to the	cause(s)	and manner as	s stated.
	the H in 24 the F the F	Medical	one)	and manner stated.	ation and or in				Julied at the title			
	To To	2	29b. Signature and title of certifies	1.01	1	2	9c. License	number		29d. Dat	te signed (Mont	th, Day, Year)
•			Juc/	vient, l			D1929	4		Aug	gust 11	, 2006
	OJ			ompleted cause of death (fits			~ .	. 1		0007		
			John/R. Melnick M 31. Date/filed (Month, Day, Year)	.D. 911 Rus				thersbu	irg, MD	208/9	9	
	Sta Registi			006 Agence	H. A	mel						

State of Maryland / Department of Health and Mental Hygiene 2006 27464 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Charles Lorenzo Radcliffe 12, AUG 2006 1:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Truman Drive, #319 Upper Marlboro 500 N. Harry S. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 10 M 2 □ F 64 08/18/1941 Director 224-50-7617 Virginia Usual Residence of Decedent with the Maryland r 28a-f ehow 10h. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Upper Marlboro Maryland Prince Georges Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or the Medical Examiner must be 500 N. Harry S. Truman Drive, #319 20774 United States death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black ģ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if item 27 is marked other then 'eny injury or other treumatic event, tra Magnice. Elementary/Secondary (0-12) Coltege (1-4or 5+) Cement Finisher Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Johnson Radcliffe Alice Charles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 MD 500 N. Harry S. Truman Dr., #319, Upper Marlboro, Jane E. Radcliffe / wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or of Anatomy Gifts or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/14/2006 Hanover, MD Registry

22. Name and Address of Facility
Thibadeau Mortuary Service, P.A.

Thibadeau Mortuary Service, P.A. 4 Donation 5 Other (Specify) 21. Signature of Furteral Service Lice M00956 20910 933 Gist Ave., LL, Silver Spring, MD Approximate Interval Between Onset and Death 23a. Part f. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER - METASTATIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events PANCREATIC CANCER Due to (or as a consequence of) Examiner be executed ettending physicien and for use as the burial-transit NICOTINE ABUSE resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the et ☐Yes 2☐No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 been si 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 🗌 No 2 No 1 Tyes 1 Yes Division of Vital Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. м investigation 2 Accident after death filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place ol Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aff To the Funerel Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of contilier 29c. License number 29d. Date signed (Month, Day, Year) AUGUST 14, 2006 D0030666 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John W. Bedeau, M.D., 1450 Mercantile Lane, #217, Largo, MD 20774 31. Date filed (Month, Day, Year) AUG 15 32 Registrar's Signature State Registrar

			1 - For State Registrar	State of Marylar	nd / Depa <i>Cer</i>	rtment <i>tificate</i>	of Healtl of Dea	n and M th	ental Hyo	gieng 0	06	2	7465
	Physicia /Medic		1. Decedent's Name (First, Middle, Las.  Magdelin	ne Cecelia Som	ervill				2. Date of Dea Month August	Day 2	Year 2006	1	ime of Death 0:25A M
	Examin Funeral Director		4a. Facility Name (If not institution, give 44952 Hewitt 5. Social Security Number 228-40-9650	Road		If Under 1	Valle Year If Uno Days Hour	y Lee der 24 Hrs.	8. Date of Birt (Month, Day Nov. 27	St h, Year)		ry's	State or Foreign
filed within 72 hours after death with the Maryland	ne 23a or 28a-f ehow	eral Director	Usual Residence of Decedent   10a. State   10b. County	10c. Ci	ty, Town or Loc	10f. Zip (	Code 2	a11ey 0692	Lee	10g. Citizen o Un		10d. In: 1[ puntry?	side City Limits XYes 2 □ No
	f Health and Mental Hygiene. item 27 is marked other than "natural", or iteme 23s or 28s-f ehow other traumatic event, the Mcdical Examiner must be notified at	Completed by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th  17. Father's Name (First, Middle, Last)	1 ☐ Yes 2X No If Yes, Give Year or Dates:  ducation ade completed)  College (1-4or 5+)  16a. Dece (Give life.		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I I Yes 2 XNo Specify:  edent's Usual Occupation s kind of work done during most of working DO NOT use retired)  Cook  18. Mother's Name			ng	Specify: Blace 16b. Kind of Business/Industry  U.S. Governm			
al y la	should be nd Mental marked o umatic eve	To Be	James Marcellous Somerville			g Address (	Mary Agatha Coates  ddress (Street and Number or Rural Route Number, City or Town, State, Zip Code)						)
	permit. Prages   and z Department of Health a Important: if item 27 is any injury or other trai		Robert S. Somer  20a. Method of Disposition  1 Burial 2 Cremation 3 4  4 Donation 5 Other (Specify	20b. I Removal from State	Place of Disposemetery, crem	sition (Name natory or oth	e of ner <b>Cenn</b> .	D	Leonar	20c. Location			tate
Dail	Departme Importan any injur		21. Signature of Funeral Service Licens			. Name and	Address of Fa	cility St	ewart F		Hom	e	
201	Physician paragraphy is the private state of the pr	edical Examiner	23a. Part. Enfet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hard failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition resulting in death)  Approximate Interval Between Onset and Death Canal Grant (ANCER)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										val Between et and Death
o death certifica	iss man the death certificate be executed igned by the attending physicien and be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							23d. Date of delivery Month Day Year			
L fep	w requires man been signed b should be deta	þ								acco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown			
To the Hospital or Attending Physician: The law requires that the death certif	certificate has ber rector, page 2 sho	Certification: To Be Completed							24a. Was autop perfor 1 Yes	sy		completio	ndings available on of cause of
	atending Priystotan: The la death. ctor: After this certificate has y the funeral director, page 2		25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be	М	3c. Injury at Work? 1   Yes 2   No				e Number.				
3	To the hospital of Attent within 24 hours after death To the Funeral Director: completely filled in by the												
;	io the hospital or within 24 hours afte To the Funeral Dis completely filled in	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated.  29b. Signature and title of certifier  29c. License number						29d. Date signed (Month, Day, 1			'ear)	
	Sta Registr		30. Name and address of person who d		24035		e Notch	n Road	, Holly			2063	

			For Stata Ragistrar	State of Marylar		artment of H rtificate of I		ental Hygier Reg. I		21400	
	Physici		Decedent's Name (First, Middle, La FRANK SABELLA	st)				2. Date of Death	2006 Year	3. Time of Death 8:00 P <sub>M</sub>	
2	/Medic Examin		4a. Fecility Name (If not institution, give street and number)  Villa Rosa Nursing Home  4b. City, Town, or Location of Death Mitchellville  Prince Ge								
	Funeral Director		5. Social Security Number 6. S	Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea Aug. 31,	9. Birt 1918 New	hplace (State or Foreign	
	and w		Usuel Residence of Decedent  10a, State 10b, County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits	
	Maryli -1 sho	tor			itchel					1 <b>∑</b> Yes 2 □ No	
	th with the 23e or 28s	Funerai Director	10e. Street and Number 3800 Lottsford			10f. Zip Code	20721	10g. (	Citizen of What Co USA	puntry?	
920	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or items 23a or 28a-f show any injury or other traumetic event, it a Medical Examinar must be notified at 90ce.	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	lispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.	
5-0	"netu	ieted	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	durina most of workin	16b.	. Kind of Business/	Industry	
21215-0036	d withir jiene. r then ir e Mi	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)			"Maintenar	nce (	City of N	New York	
Maryland	uld be filed dental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  Caterina Sinagra								
, Mary	and 2 shoi ialth and N 1 27 is ma er traume	Y 19	19a. Informant's Name/Relationship Patricia Brenna	• • • • • • • • • • • • • • • • • • • •		ng Address (Street Gettysbu	and Number or Rural irg Lane (	Route Number, Cit College Pa		Zip Code) 20740	
Baltimore,	Pages 1 ament of He ent: If item ury or oth		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 ▼ 4 □ Donation 5 □ Other (Special Content of the Content	Removal from State Pi	cemetery, crei nelawn		Park 8-1	4-06 Pi	Location - City or nelawn, N		
Balt	permit. Depertimport		21. Signature of Funeral Service Lice	ax. Pux	3en 6	Name and Addre	ss of Facility BEAI cain Hwy.	LL Funera Bowie, M	1 Home D 20715		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition  Pneumonia  Davs								
			resulting in death)	Due to (or as a consequence of):						Days	
	4	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Parkinson's Disease years  Due to (or as a consequence of).							
	ecuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
68760,	ficate be executed physician and s the burial-transit	edicai E		Due to (or as a consequence of):  d.							
P.O. Box 68	The law requires thet the death certific Ite has been signed by the attending p vage 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	excedent pregnant ast 12 months?  s 2 \( \) No \( \) No \( \) \( \) Live birth 2 \( \) Fetel death 3 \( \) Ectopic pregnancy \( \) A \( \) Ectopic pregnancy \( \) A \( \) Pregnant at time of death 5 \( \) Other (specify)							
	quires thet in signed b uld be dete	þ	Part in. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.							bute to the cause of death?  3 Probably 4 Munknown	
Il Reco	The law re rate has being page 2 sho	Completed						24a. Was an autopsy performed'	? prior to death?	utopsy findings available completion of cause of 2 No	
Vita	slcian: certific irector,	Be	25. Was case referred to medical examiner?	Hospital:	7FD/0	Oth	26. Place of Death				
Division of Vital Records,	Attending Physician: or death. ector: After this certifica by the funeral director, I	tion: To	1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?  28d. Describe how injury occurred  28d. Describe how injury occurred						cify)	
	or Atten after deal Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office 28f. Loc					cation (Street and Number or Rural Route Number, ty or Town, State)		
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai C	29a. Certifier to Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my kniminer: on the basis of examinated manner stated.	owledge, deati ation and/or in	h occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cause of at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifler	lin	Khn	29c. Licens	226/		Date signed (Monti		
)	(9)		30. Name and address of person who			Print)					
	Sta	te.	Dr. Richard Feld 31. Date filed (Month, Day, Year)	Pagistrar's Sign	atuso		Lanham, MD	20706			
	Registr		AUG 1 4 2006	and the same of th	Aper	E .					

State of Maryland / Department of Health and Mental Hygiene Reg. No. 006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 8:05 AM 4b. City, Town, or Location of Death 2006 /Medical 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner heverly Frince Georges If Under 24 Hrs. 7. Age (In yls. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country). 6. Sex **Funeral** Days 1∰M 2□ F 579-24-5148 Usual Residence of Decedent Director Pagas 1 and 2 should be filed within 72 hours aftar daath with tha Maryland nant of Haaith and Mantal Hygiana. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 HYES 2 No Funeral Director Trince Georges r than "natural", or items 23s or 28s-f the Medical Examiner must be notifie 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 20743 1207 Acidison 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ HO Specify Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry merked other than Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Be Shorter 19a. Informant's Name/Relationship (Type Charlotte Haalth a 20b. Place of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State = 5 **Separtmant** 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Funeral Ralph Williams 20003 1813 Potomac Ave. S.E. Washington 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Be Completed by Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 2X No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? ace maker 2 X No 1 ☐ Yes 2 🗷 No 1 Tyes 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 2 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Director: Aftar this 27. Manner of Death Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred edicai Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No daath. 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) fillad in by 4 ☐ Homicide hours aftar To the Hospital within 24 hours a To the Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier complataly (Check only one) 29d. Date signed (Month, Day, Year) 29b Signature and title of certific 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 8416 -batch 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 4 2006 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygien 20627468 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Shah August 19, 2006 Panachand 3:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15605 Oak Glen Circle **Hughesville** Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 9,1928 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Min 1 □ M 2 1 F Months Days Hours 218-04-4753 77 Director Indía Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show th and Mantal Hygiene. 27 is marked other than "natural", or Itame 23s or 28a-f shov traumatic event. It a Medical Examinar must be notified at 1 Yes 2 No Directo Maryland Charles Hughesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If them 27 is marked other than "--- any injury or other traumeti- any injury or other traumeti-15605 Oak Glen Circle 20637 India Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② CNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: 3€Widowed 4 □ Divorced Indian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **Himatlal** Trikamlal Sanghvi Chanchalben Sanghyi ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Mahesh P. Shah/Son 15605 Oak Glen Circle, Hughesville, Maryland 20637 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Brinsfield-Echols Cr. 8/20/2006 Charlotte Hall, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligens Brinsfield Fichols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SCLE ROSIS Immediate Cause (Final AMYTROPHIC LATERAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 month 2 Fetal death 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signer should be d 3 Probably 4 Unknown 1 🗌 Yes 2000 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy periotined Yes certificate 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical examiner? 26. Place of Death / Check only Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 27. Myrns of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending - Accident death. investigation 1 ☐ Yes 2 ☐ No nerel Director: , filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a
To the Funerel C Cartifying Physician: To the best of my knowledge, death construct at the time, date and plane, and due to the nause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifier Physica -Allender 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AN WIA 2 MUNSHI, MD 110 HOSPITAL RD. PRINCE FREDERICK MD 20678 31. Date filed (Month, Day, Year) AUG 2 1 206c 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 2006

		For State Registrar  1. Decedent's Name (First, Middle, Last)		Cei	lilicate	of Death	2. Date of Dea			3. Time of Death
Physicia		Shelby Je	ean	Smith			August	18,	2006	3:24 A M
/Medica Examine		4a. Facility Name (If not institution, give s		DIRECTI	4b. City, Tox	vn, or Location of Deat			County of Death	
LAGITITIC		14345 Smallwood Dr:	ive		Hugh	nesville			Charle	S
uneral irector		214-48-7766	M 2. ♣F 7. Age	(In yrs. last birthday) 60 Yrs.	If Under 1 Y Months D	ear If Under 24 Hrs ays Hours Min.		1946	9. Birth Cou Kent	place (State or Foreign ntry) Lucky
>	-	Usual Residence of Decedent  10a, State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
23a or 28a-f show	ŏ			,,						1 ☐ Yes 2 📉 No
28a-	ect	Maryland Charle  10e. Street and Number	5	Hughesvi	10f. Zip Co	de		10g. Citiz	en of What Cou	ntry?
3a or	٥	14345 Smallwood Dr	ive		1	637		U	S A	
or Item referen	Ē	1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🖔 No If Yes, Give		Was Deceden If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)		4. Race - Ameri Black, White, Specify:	etc.
naturel',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:						Wn	ite
nat	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece (Give	dent's Usual C kind of work of DO NOT use t	ccupation lone during most of wo etired)	rking	16b. Kin	nd of Business/In	idustry
irthen ire Ma	m	Elementary/Secondary (0-12)	College (1-4or 5+	) 1	memake			Оъл	1 Home	
	ပိ	17. Father's Name (First, Middle, Last)			momare	<del></del>	me (First, Middle,			
D A	o B		ankenship			Kelsa	Pr	cater	2	
mati	Ĕ.	19a, Informant's Name/Relationship (Type	oe, Print)	19b. Mailii	ng Address (S	treet and Number or Ri	ural Route Numbe	r, City or	Town, State, Zij	D Code)
27 ls		Penny Evans/Daught	er	4022	5 Hidde	en Meadow I	ane Med	hani	icsville	MD 20659
riant: if tem 27 is marked njury or other treumatic ev		20a. Method of Disposition		20b. Place of Dispo	osition (Name	of !	Date		cation - City or T	
y or		P☐Burial 2 ☐ Cremation 3 ☐R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			Gar. 8/22	2/2006	Wa1d	lorf, Ma	ryland
injury		21. Signature of Fun rabService Licentee	Ma			ddress of Facility				-
eny injur		14	110			ree Notch			-	1 MD 2062
*	1	23a. Part1. Enter the disease, or compli	cations that caused t	he death. Do not ent					LLE nar	Approximate
		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line	n V	1					Interval Between Onset and Death
ician dical		disease or condition resulting in death)	rense	Jan.	leve					SHO
niner	İ		Due to (or as a	consequence or):						Years
	e	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	Due to sa	consequence of):						great
	E L	Cause (Disease or injury								
ial-tra	Examin	that initiated events cresulting in death) Last	Due to (or as a	consequence of):						
			I							
n ris .	Aedical									
for use	<u>S</u>	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of 1□Live birth 2		⊒Ectopic pregi	nancy.		2	3d. Date of deliv	
pg to	ic la	in the past 12 months?	4☐ Pregnant at ti		Other (speci				Month	Day Year
tached	Physician/A	9 Unknown	9Ll Unknown			-				
	by P	Part II. Other significant conditions con	tributing to death but	not resulting in the u	inderlying caus	e given in Part I.	23e. Did to	bacco us	se contribute to t	the cause of death?
blud E							1 D Y	′es 2□	No 3☐ Pro	bably 4 Dunknown
2 should	Completed						24a. Was		24b. Were auto	opsy findings available
page 2	E							rmed?	death?	ompletion of cause of 2 No
d. Tor.	0	25. Was case referred to medical				26 Place of De	1 ☐ Yes ath Check only o		1 1 103	2   140
6	ToB	examiner?	lospital: 1  Inpatien	t 2 ER/Outpatier	nt 3 DOA	Other	tome 5 Resid		□Other (Speci	fv)
		27, Manner of Death	28a. Date of Injury (Month, Day	28b. Time o		Injury at Work?	28d. Describe h			.,,,
Ę.	후	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	м	Work? 1 ☐ Yes 2 ☐ No				
d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, sti (Specify)	reet, factory, o	ffice	28f. Location (S City or Tow			al Route Number,
		29a. Certifier (Check only one)	nor: On the basis of e and manner state	examination and/or in	h occurred at to exestigation, in	he time date and plan- my opinion, death occ	a and Sua to the r urred at the time, o	date and	and trannal as a place, and due t	to the cause(s)
~ = o	dica				29c I	icense number		29d Date	signed (Magth	
= =	Medical	29b. Signature and title of certifier			200. 2	oonee married.	1		signed (Month,	Day, Year)
=	Medica	29b. Signature and title of certifier	21 ma					_		
=	Medica	Thek	2h and	Other Control	Do	1923 1		_	9 18,	
ā = I	Medica	30. Name and address of person who co			Print)	1923 1		_		
he Funer	Medica	Thek	son		Do	1923 1		_		**

State of Maryland / Department of Health and Mental Hygien 2006 27470 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JOHN V. SILLIMAN AUGUST 13 2006 3:36PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WILLIAM HILL MANOR EASTON TALBOT If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 1 M 2 □ F Months 158-09-8562 Director 91 JUNE 9, 1915 OHIO Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir Items 23a or 28e-f show ther nast be notified at 1X Yes 2 □ No Director MD TALBOT EASTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **501 DUTCHMANS LANE** 21601 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 😿 No Specify: Specify: þ WHITE 3 Widowed 4 Divorced Year or Dates: Completed h and Mental Hygiene.
7 is marked other than "natuitreumetic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ENGINEER GRAPHIC ARTS 12 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental I ent: If item 27 is marked of **GUY SILLIMAN** 2 MARIE KNORR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i DONALD W. SILLIMAN/SON 200 3RD ST., OXFORD, MD 21654 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State = 5 Department o Importent: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR. 8/16/2006 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Ostzonsh. OSep 4 200 S. HARRISON ST EASTON, MD 21601 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) second Pnysician isaleo /Medical Due to (or as a cons - uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner siclan and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of Box 68760, Physician/Medicai the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2□ No 1 Yes 22 No Division of Vital To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other P 1 🗆 Yes 2 🗀 ઍઇ 2 ER/Outpatient 3 DOA Windle Solution Williams Williams Williams Williams Williams Solution (Specify) After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Matural 5 Pending investigation death, 1 Tyes 2 No 2 Accident Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 501 DUTCHMANS LANE, EASTON, MD 21601 WILLIAM H. WOOD, JR., 31. Date filed (Month, Day, Year) State Registrar AUG 1 7 2006

			For Stata Registrar	State of		artment of Health and rtificate of Death		eg. No.	21411
	Physici	an l	1. Decedent's Name (First, Mi		Cincon		2. Date of Deal Month	Day Year	3. Time of Death
	/Medic		Nicholas		Singer		8.0	13 2006	12:20P M
	Examin	er	4a. Fecility Name (If not institu 3838 Dakot		ber)	4b. City, Town, or Location of Deat Hampstead	n	4c. County of Death	
			5. Social Security Number		. Age (In yrs. last birthday)	-	· 8 Date of Birth	Carroll	place (State or Foreign
	Funeral Director		219-40-1758	Ma 2□F	63 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day)	2010	ryland
	D		Usual Residence of Decedent						
	arylar show	_	10a. State 10b. Cou	•	10c. City, Town or Lo			1	0d. Inside City Limits 1 Yes 2 No
	Be-f	ecto		arroll	Hampst			0g. Citizen of What Cour	
	with t	Funeral Director	10e. Street and Number	D 3		10f. Zip Code	'		iti y r
	leath ns 23	eral	3838 Dakota  11. Marital Status	12. Was Deced	dent Ever in U.S. 13.	21074 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	USA 14. Race - Americ	ean Indian,
36	it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland riment of Heatth and Mental Hygiene. rient: if item 27 is marked other than "naturel; or items 23a or 28e-1 show njury or other traumatic event, the Medical Examinar must be notified at	by Fun	1 □ Never Married 2 □ N  3 ◯ Widowed 4 □ Divore	If Yes, Give	No No	If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes <b>3</b> ☐ No <i>Specify:</i>	to Rican, etc.)	Black, White,  Specify: White	
21215-0036	2 hou	ted	15. Dece	dent's Education ghest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of wo	rking	16b. Kind of Business/In	
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<u> </u>	d Men marke	P	Leroy R.  19a. Informant's Name/Relati	Singer, Sr		Maria ng Address (Street and Number or R	M. Es		Code
Ma	d 2 sho th and t7 Is ma traum		Wayne C. Retz			Winans Ave., Hal			Codey
စ်	Heal Heal tem 2		20a. Method of Disposition		20b. Place of Dispo			20c. Location - City or To	own, State
<u>o</u> E	Pages nent of int: If It iry or o		1 ☐ Burial 2 【XCremati `4 ☐ Donation 5 ☐ Othe	on 3 Removal from S r (Specify)			.4-2006	Hampstead, N	4D 21074
Baltimore,			21. Signature of Funeral Serv		2	2. Name and Address of Facility			
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			23a. Part1. Enter the disease shock, or heart failure.	e, or complications that ca List only one cause on ea	used the death. Do not en ch line.	ter the mode of dying, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
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	uted d ansit	Examiner	Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Hen	Der Jensi	ue shock ward infant. he Caedirah	dalas	Diame	10 415
o,	ificate be executed g physician and as the buriat-transit	Exa	resulting in death) Last		or as a consequence of):				
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Вох	death certif e attending od for use as	lan/I	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir		Ectopic pregnancy		23d. Date of delive Month	ery Day Year
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4	that the de ed by the a detached f	Ph		ditions contributing to dea	ath but not resulting in the u	inderlying cause given in Part I.	23e. Did to	bacco use contribute to the	ne cause of death?
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Sor	w requ	Completed					24a. Was a	n 24b. Were auto	psy findings available
Re	e ta has	duic					autops	sy prior to co	mpletion of cause of
ta		a	25. Was case referred to med	dical		26. Place of De	1 ☐ Yes : ath (Check only on		20110
Ž	Physician: this certific al director,	To B	examiner? 1 X Yes 2 ☐ No	Hospital: 1 🗆 In	patient 2 ER/Outpatie	nt 3 DOA Other: 4 Nursing I	Home Kaside	ence 6 Other (Specif	y)
0			27. Manner of Death 1 Natural 5 ☐ Pe	28a. Date of (Month)	f Injury 28b. Time of Injury	of 28c. Injury at Work?	28d. Describe ho	ow injury occurred	
Sio	Attending r death. sctor: After y the fune	catle	2 Accident inv	estigation		M 1 Yes 2 No			
Division	F 0 F C	Certification:	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide del	termined 200. Flace	of Injury - At home, farm, st g, etc. <i>(Specify)</i>	reet, factory, office	28t. Location (Si City or Town	treet and Number or Rura n, State)	al Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by		29a, Certifier 1X Cert	ifving Physician: To the	hest of my knowledge, doc	th occurred at the time, date and plac	and due to the c	ause(s) and manner as s	tated
	Hos 24 hc Fun etely	edical	(Check only 2 Madi	ical Examinar: On the bar and manner	sis of examination and/or in	nvestigation, in my opinion, death occ	urred at the time, d	ate and place, and due to	the cause(s)
	Fo the within Fo the	Me	29b. Signature and title of cer	- N - 0 - 0	M	29c. License number 1000	31921 2	9d. Date signed (Month,	Day, Year 8/16/16.
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b*	15		30. Name and a rress of per	son who completed cause	of death (Item 23a) (Type	Print) A 37:	71 D.	lan Call	
100	12		SILVIN	e MUN	VE EC	14.0. 37	R	to me	d 21225
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100	Regist	at .	Δ111-	6 2006	TURE AS AS				

			For State Registrar	te of Maryland / D	Depai <i>Cert</i>	rtment of He rificate of D	ealth and M Death		iene <mark>2 0 0 (</mark>	27472
	Physici		Decedent's Name (First, Middle, Last)  Dana Edward Sanford					2. Date of Deat Month August	11 2008	3. Time of Death 10:10 PM
	/Medic Examir		4a. Facility Name (If not institution, give street a  548 Uniontown Road	and number)		4b. City, Town, or L Westmi			4c. County of De	
**************************************	Funeral Director		5. Social Security Number 6. Sex 1 (■ 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last birt		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, August	<sup>Y</sup> 1931 <sup>9. B</sup>	inthplace (State or Foreign Country) Mass
	Maryland f show	or	Usual Residence of Decedent  10a. State 10b. County  MD Carrol1	10c. City, Towr		ation minster				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	sa or 28a-	Il Director	10e. Street and Number 548 Uniontown Road			10f. Zip Code <b>211</b>	.58	10	og. Citizen of What C	*
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, tra Medical Examinar must be notified at once.	Completed by Funeral	11. Marital Status 12. Wa Arri 1 Never Married 2 Married 1 15 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	s Decedent Ever in U.S. ned Forces?  Yes 2 No 1952 es, Give ar or Dates: 1954	lf '	as Decedent of His Yes, specify Cuban	panic Origin? (Spo , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	within 72 hounder.	mpleted	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) Co	16a.	(Give ki life. D	ent's Usual Occupat ind of work done du O NOT use retired)	ring most of work	ing	16b. Kind of Busines	
	ud be filed v lental Hygie rked other t lic event, III	To Be Co	12 17. Father's Name (First, Middle, Last) Chester A. Sanford		50	ore Manag	18. Mother's Name Nettie			7.0010
, Maryland	and 2 shoualth and Market 127 is mailer traumater		19a. Informant's Name/Relationship (Type, Pri George Davis/son	nt) 19b.		Address (Street ar Uniontow		al Route Number, <b>Westmin</b> s	City or Town, State, Ster, MD	Zip Code) 21157
Baltimore,	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Remova 4 □ Donation 5 □ Other (Specify)	Lifrom State cemeter	ry, crema	ition (Name of atory or other place, remation,	)	714/2006	20c. Location - City of Hampste	
Balt	permit. Departi		21. Sign three of Funeral Service License	2	4	12 Washir	ngton Roa	ad Westr	napel, P. <i>R</i> minster, M	
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	To Be	25. Was case referred to medical examiner?  1  Yes No Hospita  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Date of Injury 28b. T	utpatient Time of Injury	3 DOA Other		me 5 Reside	a) nce 6 ⊡Other ( <i>Sp</i> w injury occurred	ecify)
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	the Hospit in 24 hour the Funera pletely fills	edical	(Check only 2 Medical Examiner: O	To the best of my knowledge in the basis of examination and id manner stated.	death nd/or inve	estigation, in my opi	nion, death occurr	ed at the time, da	ate and place, and di	ue to the cause(s)
	MIL	Σ	29b. Signature and title of certifier	Scho II M	V	29c. License	number 1660		9d. Date signed (Moi 08)14/20	
	나		30. Name and address of person who complete  20\ STONEL AVE  31. Date filed (Month, Day, Year)	ed cause of death (Item 23a) (  LUC LUCS TO  32. Registrar's Signature	(Type, P	stla ma	muland	21157	Thomas 1	K. GALVIN, M.D.
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			For State Registrar		State	of Mai	ryland /	Depai <i>Cert</i>	rtment d tificate	of He of D	alth and eath	Mental H	ygien Reg. N	1e20	06	27473
₩ 5	38		Decedent's Name	e (First, Middle, La	st)		_					2. Date of D		ay	Year	3. Time of Death
	Physicia /Medic		Dona1d	Ρ.	Stud	ld					-	AUGU	ST I	15,20	06	8:45 A <sup>M</sup>
<b>U</b>	Examin	100	4a. Facility Name (In	f not institution, giv	e street and n	number)					ocation of Dea	ith	4	tc. County of		
9		8	VA MARY  5. Social Security N				SYST		PERR If Under 1 Y		OINT If Under 24 Hr	s. 8. Date of E	lirth	CECI		place (State or Foreign
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NC	and and	-	Usual Residence of 10a. State	10b. County			10c. City, To	wn or Loc	ation						1	0d. Inside City Limits
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ru	death with the Maryland ims 23a or 28a-1 ehow r must be i willied at	aiD	5331 Fiv	e Fingers	s Way				21	045			Uni	ited S	tate	es 
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-1 ehow eny injury or other treumatic event, the Medical Examiner nust be indiffed at once.	d by Funeral Director	11. Marital Status 1 Never Marri 3 Widowed		1 X Yes If Yes, 0 Year or	Forces?	/3/46 /7/51	1	□Yes 2█	No	Specify:	Specify Yes or I into Rican, etc.)		Specify:	White,	e
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<b>5</b> ₩	filed Hygi other ent, I	ВеС	17. Father's Name		)					-	8. Mother's N	ame (First, Mido	le, Maide	en Sumame	9)	
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다. <b>ary</b>	s mail		19a. Informant's Na		Type, Print)			,				Rural Route Num				_
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NAME KNOWN TO PHYS  Baltimore, Maryland 21.	Pages 1 Iment of He tant: If iten jury or oth		4 Donation	☐ Cremation 3 [ 5 ☐ Other (Speci	(y) 1	m State	cemet	өгу, crem side —	ction (Name atory or othe Cemete	rplace) ery	Aug	Date ust 21, 2006	На	amburg	, NY	
Ball Ball	permit Depart Impor eny in		21. Signature of	meral Service Lice	11/72				Name and A			Crouch F North				901
			23a. Part1. Enter the disease, or complications that are ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. CEREBROVASCULAR ACCIDENT													Approximate Interval Between Onset and Death
7	Physician /Medical Examiner		disease or condition resulting in death)	on <b>(</b>			consequenc		_ACC1	DEI	NT					UNKNOWN
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rds	quires n sign	d b	RESPIRA	ATORY FA	ALLURE	RE	ENAL I	PAIL	URE			_ 1[	Yes	2 🗆 No	3 🗌 Prot	bably 4 Unknown
Reco	: The law requir cate has been si , page 2 should	Completed										24a. W au pe 1 ☐ Yes	topsy rformed	? 0	rior to co	opsy findings available impletion of cause of
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>	nysician: nis certific I director,	To	examiner?	No	Hospital:	☐ Inpatien	nt 2□ER/0	Dutpatient				Home 5 □ Re				fy)
Division of Vital Records, P.O	Afte fune	27. Manper of Death  1 Natural  28a. Date of Injury  (Month, Day Year)  28b. Time of 28c. Injury at Work?  1 Yes 2 No  3 Suicide 6 Could not be 38c. Place of Injury. At home larm street factory office.									28d. Describ				al Route Number,	
Div	urs after orel Direc		4  Homicide	determine	N. laye							City or	Fown, St	tate)		
	To the Hospitel or Attenwithin 24 hours after death To the Funeral Director:	ledical	29a. Certifier (Check only one)	1 Certifying F	miner: On the		examination .		restigation, in	my opi	nion, death oc		e, date a	and place, a	and due t	o the cause(s)
	To vith	Σ	29b. Signature and	a title of certifier	S	.50	dh			16ense 142(	number			GUST		2006
F	541VA		30. Name and add	ress of person who									_			
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2006

			1 - State Registrar	,	C	ertificate of	Death		Reg. No.	00	L 1311
		· 6.	Decedent's Name (First, Middle,	Last)				2. Date of De Month		Vear	3. Time of Death
	Physici /Medic		Beverly	Scri	Lbe			August	13, 2	006	10:10 A M
	Examir		4a. Facility Name (If not institution,	give street and number)		4b. City, Town,	or Location of Deat	h	4c. County		
	- 19 g 1	, (c	Genesis Elder C			Annapo				Arur	
Ā,	Funeral			1 CIM OFT	yrs. last birthda Yrs.	y) If Under 1 Yea Months Day:		(Month, Da	th y, Year)	9. Birthp	place (State or Foreign
47	Director		185-26-3037 Usual Residence of Decedent	73				April 2	27, 1933	Penr	nsylvania
	ehow		10a. State 10b. County	10c	:. City, Town or	Location					10d. Inside City Limits
	Many Fired	tor	Maryland Prince	George Bo	owie						1 K Yes 2 No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?
	23a c	a	12202 Millstream	Drive		20715			United	State	es_
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13	3. Was Decedent of tf Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	pecify Yes or No o Rican, etc.)	- 14. Rac Bla	ce - Americ	can Indian, etc.
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to C Health and Mental Hygiene. If Item 27 is marked other than "netural", or Items 23s or 28s-1 show or other traumatic event, the Medical Example routing a	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2 🛣 No	Specify:		Specif	y:	
21215-0036	hour turel	Q D	15. Decedent's	Year or Dates:	16a Dec	cedent's Usual Occi	ination		16b. Kind of B	Whit	
75	in 72	Completed	(Specify only highest	grade completed)	(Gi	ve kind of work don  . DO NOT use retir	e during most of wo	rking	TOD. KAIG OF E	U3111033V111	dustry
7	with iene.	mo	Etementary/Secondary (0-12)	College (1-4or 5+)	Home	emaker			Home		
	illed Hygi other	BeC	17. Father's Name (First, Middle, La	rst)			18. Mother's Nar	ne (First, Middle,	Maiden Sumar	ne)	
<u>a</u>	should be fand Mental Bemarked of	To B	John Poida				Pauline	Pavlick			
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than surmatic event, the Ms		19a. Informant's Name/Relationshi	(Type, Print)	19b. Ma	iling Address (Stree	et and Number or Ru	ıral Route Numbe	er, City or Town	, State, Zip	Code)
	1 and 2 Health tem 27 l		Janice Hughes/Da	9			Lane, Owi				
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		Ob. Place of Dis cemetery, c	position (Name of rematory or other pi	ace)	Date	20c. Location	- City or To	own, State
Ē	Pages ment of I ant: if it		4 □Donation 5 □ Other (Spe		Gilmore	Cemetery	8/14	/2006	Sinnama	homin	g.PA
Baltimore,	permit. Page Department Important: if any injury o		21. Signature of Funeral Servine Li	alex	(	George Pd 2973 Solo	™KafasyFu mons Isla	neral Ho	me, P.A Edgewat	er. N	Md 21037
- %			23a. Part1. Enter the disease, or c	omplications that caused the o							Approximate Interval Between
E	Physician		shock, or heart faiture. List o Immediate Cause (Final	•	3700	inhai	how de	1	1.		Onset and Death
1	/Medical		disease or condition resulting in death)	a. Due to (or as a con		34(""	Proce oc	m. Culv.	7 011	UH	392
	Examiner			h							
No.	B #	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	nsequence of):						
	death certificate be executed e attending physician and infor use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
68760,	e exection a		resulting in death) cast	Due to (or as a con	isequence of):						
876	ate b	Medical	<b>'</b>	d							
9 x	entifica ding ph	-	IF FEMALE:	23a If you outcome of pe	0000000						TE 170
Вох	eath cer attendin for use	Physician	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 Live birth 2 1 4 Pregnant at time	Fetal death	B Ectopic pregnan	су			ate of delive onth	ery Day Year
o.	he de / the ched	ysic	1 ☐ Yes 2 ☐ #o 9 ☐ Unknown	9 Unknown	or death .	o⊟ Other (specily)					
٥.	The law requires that the de ate has been signed by the a page 2 should be detached t		Part II. Other significant condition	s contributing to death but not	t resulting in the	underlying cause g	given in Part I.	23e. Did t	obacco use con	tribute to t	he cause of death?
of Vital Records,	uires 1 sign 1d be	d by						11/23	Yes 2□No	3 🗆 Prot	oably 4 Unknown
CO	w requ	Completed						24a. Was	an 24b	Were auto	opsy findings available
Re	he fav e has	mc						autor	osy ormed?	prior to co death?	empletion of cause of
ī		ပိ	25. Was case referred to medical				26 Place of Dog	1 ☐ Yes	7-10	1 🗌 Yes	2∐ No
>		To B	examiner? 1 ☐ Yes 2 ☑ № No	Hospital:	2 ER/Outpat	ient 3 DOA	thos	lome 5 ☐ Resid		ner (Specii	fv)
0	g Phys er this eral di		27. Manner of Death	28a. Date of Injury (Month, Day Yea		of 28c. Inj			how injury occur		,,
Ö	Attending or death.	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	,,		∐Yes 2 □ No				
Division	r Atterdering the color of the	Certification:	3 Suicide 6 Could no 4 Homicide determin		At home, farm,	street, factory, office	9	28f. Location (S City or Tox	Street and Numi vn, State)	per or Rura	al Route Number,
	ital o		- File								
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	edical	(Check only 2 Medical E	Physician: To the best of my kaminer: On the basis of exar and manner stated.	rknawladge, de mination and/or	ath occurse at the investigation, in my	thing, date and place opinion, death occu	rred at the time.	cause(s) and m date and place,	and due to	tated. o the cause(s)
	To th within To th	Me	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signe	d (Month,	Day, Year)
			> 1 1) kg	cun		0	P2136		8/11	4/1	006
	~		30. Name and address of perion w	no completed cause of death	(Item 23a) (Typ				, .		_
1122-1	8		Gary J. Sprouse	2108 DiDonat	o Drive	e, Cheste	r, Maryla	nd 21619			
Y.	Sta		31. Date filed (Month, Day, Year)	32. Resistrar's S 5 2006	Signature	Aug. 11 -					
100	Regist	ar	AUG 1	O LOUW ASSESSED	15	Line of the last o					

ı	Physici	an	1 - State Registrer AMEND 29d, per N 1. Decedent's Name (First, Middle, Li	ast)	co Ce	rtificate o	Death	2. Date of Dea Month August		Year	3. Time of Death 8:00am M
7	/Medic Examir	cal	Warren Harry S  4a. Facility Name (If not institution, gi  Montgomery Gener	ve street and number)		4b. City, Town,	or Location of Dea		4c. County Montg		
	Funeral Director		5. Social Security Number 6. 500-22-3011		rs. last birthday Yrs.	Months Day			, 1917		olace (State or Foreign (Tadelphia, P.
	he Maryland Ba-f ehow cultied at	ector	Usual Residence of Decedent		City, Town or L Silver	Spring			10- ()ii()	_	0d. Inside City Limits 1    Yes 2   No
	th with t	al Dir	10e. Street and Number 3701 Internation	al Dr.#715		10f. Zip Code 20906			10g. Citizen of V		•
920	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other then "natural", or items 23a or 28a-f show important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumstic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 △ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ĀNo If Yes, Give Year or Dates:	1 U.S. 13.	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🛂 N	Hispanic Origin? (: lban, Mexican, Pue o <i>Specify:</i>	Specify Yes or No rto Rican, etc.)	- 14. Rac Blac Specify	e - Americ ck, White, Whi	etc.
15-0	n 72 ho "natur	Completed	15. Decedent's E (Specify only highest g	rade completed)	16a. Dece (Give	edent's Usual Occ e kind of work don DO NOT use reti	upation e during most of wo red)	orking	16b. Kind of Bi	usiness/Ind	dustry
212	ed withi	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)		ical Doc	tor		Medica		
Maryland 21215-0036	12 should be filed within hand Mental Hygiene. 7 le marked other then "treumetic event, the Mark	To Be (	17. Father's Name (First, Middle, Las Alvin A. Swenso					me (First, Middle, Peters	Maiden Suman	10)	
Man	12 sho h and I 7 le mu treum		19a. Informant's Name/Relationship				et <i>and Numb</i> er or R .tional Di				
Baltimore,	Pages 1 end nent of Health int: If Item 27 ury or other tr		Katharine Swens  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3    4 □ Donation 5 □ Other (Spec	□Removal from State N	D. Place of Disp cemetery, cre	osition (Name of omatory or other p	(ace)	Date	20c. Location - Falls C	own, State	
Balti	permit. Departm Importa eny inju		21. Signature of Funeral Service Lice		2		ress of FacilityJos				
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or cor shock, or hear failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	a. Due to (or as a cons	ke sequence of):	iter the mode of d	ying, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
68760,	eath certificate be executed attending physicien and for use as the burial-transit	Medical Examiner	that initiated events resulting in death) Last	CDue to (or as a cons	sequence of):						
O. Box	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	□Ectopic pregnar	асу			te of delive	ery Day Year
Δ.	w requires that been signed b should be deta	þ	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause	given in Part I.	23e. Did to		tribute to th	ne cause of death?
of Vital Records,		Completed						24a. Was autop perfo 1 ☐ Yes	rmed?	Were autop prior to cor death? 1 ☐ Yes "	psy findings available mpletion of cause of
Vita	Physician: this certificantal director,	Be	25. Was case referred to medical examiner?	Hospital:			)than	eath (Check only o		4	
ion of	Attending Physic death. sctor: After this by the funeral di	ation: To	1 Yes 2 Ho  27. Manner of Death  1 Autural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year		Time of 28c. Injury al 28d. Describe how injury occurred					<i>'</i> )
Division	in the second	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		t home, farm, s	treet, factory, offic	8	28f. Location (S City or Tox		er or Rura	l Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical (	29a. Certifying F (Check only one)	Physician: To the best of my aminer: On the basis of exam and manner stated.	knowledge, dea ination and/or i	th occurred at the nvestigation, in m	time, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and ma date and place,	anner as st and due to	ated. the cause(s)
	_	×	29b. Signature and title of certifie	an r	ID	29c. Lice	06319	6	29d. Date signe	_	Day, Year) 8/9/06
	15		30. Name and oddress of person who Hottlew How	completed cause of death (	Item 23a) (Type	Print)	wlip Dr	rive C	Lypy.	MD	20832
1	Sta Regist		31. Date filed (Month, Day, Year)	32. Pegistrar's Si	gnature	barke			1 /		

06-06285 Loretta Suman

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental

alth and Mental Hygiene ath	Reg No.	2006	274	76	

		Registrar		Certific	cate of	Death			Reg No.	200	0 2141
Physicia Medical Exami	an/	1. Decedent's Name (First, Middl Loretta E. Sum						2. Date of D Month August	eath Day 22, 2006	Year	3. Time of Death 1139 hrs
		4a Facility Name (if not institutio Montgomery General		)	41	Olney	r Location c	f Death		ounty of Death	
Funeral Director		5. Social Security Number 077-38-9860	6. Sex 7. Ag	ge (In yrs. last bi	rthday) 59 Yrs.	If Under 1 Ye		Min.	Birth(MM/DD/	Foreig	hplace (State or n untr <b>New York</b>
und show any nice.	٥r	Usual Residence of Decedent 10a. State 10b. County Maryland Mont	gomery	10c. City, Town		nsington	n				10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Dire	10e. Street and Number 11513 Rokeby	Avenue	•		10f. Zip Code 20895			10g. Citizen	of What Coun	Ť
iter death w ", or items er must be	by Funeral	11. Marital Status 1 Never Married 2 Marital 3 Widowed 4 Div	arried 12. Was Deceden Armed Forces' 1 Yes 2 orced If Yes, Give Year or Dates:	? <b>X</b> No	If Ye	Decedent of H s, specify Cuba Yes 2 No	n, Mexican, o specify	nn? (Specify Yes or Puerto Rican, etc.)	Spe	Race - Americ White, etc. ecify: Whi	can Indian, Black, te
64 2 =	Completed	15. Decedent's Education (Spec Elementary/Secondary (0-12)	College (1-4 or 5	5+)		st of working life Social	e. DO NOT			of Business/Ir	counselor
	Be Com	17. Father's Name (First, Middle, Robert E. Dewe						s Name (First, Middle helma Ride		name)	
D 21 ! should! and Mer !7 is mai	10	19a Informant's Name/Relations	hip (Type, Print)	19	9b. Mailing	Address (Stre	et and Num	ber or Rural Route N	lumber, City or	r Town, State,	Zip Code)
re, MD s I and 2 sho f Health and If item 27 is ner traumati		Frederick J. S 20a. Method of Disposition	uman/ Husban	nd 1.3 20b. Place	1513 F of Dispositi	okeby on (Name of ce	Avenue emetery,	e, Kensind August 20	ton, M	ID 2089 ation - City or	
Page nent o		1 X Burial 2 Cremation 4 Donation 5 Other Sa	pecify:			Cemet		2006	Syr	acuse,	NY
Balti Permit Departu Import	Į	21. Signature of Funeral Service	Licensee					lins Funer			g, MD 20901
Physician /Medical Examiner		23a. Part I Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line.		not enter the	mode of dying	g, such as ca	ardiac or respiratory	arrest, shock,	or heart	Approximate Interval Between Onset and Death
		or condition resulting in death)	Due to (or as a cons	equence of):							
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons								
18760, rtificate be executed ing physician and as the burial - transit			d				_				
50, te be er	an/Medical	UNPENDED  IF FEMALE:	AMENDED it	em#23a,27		,g859,9/1	/2006 1	IT	1 224 D	ato of dolly one	
	Physician/N	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 ✓ University Visit 12 No 9 ✓ University Visit 12 No 9 ✓ University Visit 12 No 9 ✓ University Visit 12 No 9 ✓ University Visit 12 No 9 ✓ University Visit 12 No 9 ✓ University Visit 12 No 9 ✓ University Visit 12 No 9 ✓ University Visit 12 No 9 ✓ University Visit 12 No 9 ✓ University Visit 12 No 9 ✓ University Visit 12 No 9 Visit	1 Live birth 4 Pregnant a	t time of death	2 Feta	Il death 3 er (Specify)	Ectopic	pregnancy	Mor	ate of delivery nth D	ay Year
ires that the death ce signed by the attend be detached for use	\$	Part II. Other significant condit		th but not resulti	ng in the un	derlying cause	gíven in Pa				the cause of death?
Division of Vital Records, rat or attending Physician: The law requirers after death an Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed								opsy formed?		copsy findings available completion of cause of s
Vital Reovision: The his certificate	Be	25. Was case referred to medica examiner?				26.Plac		(Check only one)			
n of Vir Jing Physic After this funeral dir	ဥ	1 ✓ Yes 2 No 27. Manner of Death		ent 2 🗸 ER/0	Outpatient Time of Inj		Other	Nursing Home 5	Residence		
Sion of Attending Pl r death ector: After by the funera	ation	1 X Natural 5 Pend	28a. Date of Inj (Month, Day, ding stigation	Year)			Yes 2		o tion injury o	,0041104	
Divisi pital or At ours after d teral Direct	Certification:	3 Suicide 6 Could determine determine Suicide		njury - At home,	farm, street	factory, office	building, etc	c. 28f. Location or Town		Number or Run	ral Route Number, City
To the Hos within 24 h To the Fun	Medical (	one) 2 Medical Exa	hysician: To the best of n miner:On the basis of exa and manner stated			n, in my opinio	n, death oc		te and place, a	and due to the	e cause(s)
W.Z	Σ	29b Signature and title of certifie	. 000	0			.M.E.			signed (Mon 23, 2006	th, Day, Year)
JAN .		30. Name and address of person		. ,				Nimoro BAD C16		25, 2006	
	ate	Patricia Aronica-Pollati		Medical Exar ar's Signat	niner	Penn S	ureet, Ba	Itimore, MD 212	:01		
Regis	trar	AUG 23	2006 32 Registra	ar's Signatur	A. F. Take						

		1- State of Maryland / Department of Health and Maryland / Department of Health and Maryland / Certificate of Death		Reg. No.	16 27477
Physic /Med		1. Decedent's Name (First, Middle, Last)  MARY JONES TRAYERS	2. Date of De	13 0	3. Time of Death O 6/2 M
Exami Funera Director	ř	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  We Sity of Many land Medical Carter  Baltimore  5. Social Security Number  6. Sex  7. Age unyrs last birthday)  If Under 1 Year   If Under 24 Hrs. Months   Days   Hours   Min.	8. Date of Birt		Birthplace (State or Foreign Country)
ט		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location	19/1	F	Iaryland  10d. Inside City Limits  1
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. Z7 is marked other then "naturel", or items 23s or 28s-f show traumatic event, the Modical Exeminar must be notified at	To Be Completed by Funeral Director	James Bishop Gra  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rule)	pecify Yes or No o Rican, etc.)  king  ne (First, Middle, ace Varal Route Number	Specify:  16b. Kind of Busin Baltimor Board of Maiden Sumame) (aughn er, City or Town, Sta	American Indian, White, etc.  Black ress/Industry re County Education
Baltimore, I permit. Peges 1 end Department of Healt important: if item 2 eny injury or other once.		Carroll W. Travers / Son 1922 Saratoga Street,  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Structure (Friedram Sarvice Licensee)  22. Name and Address of Facility  22. Name and Address of Facility  23. Name and Address of Facility  24. Race Street,	Date 9-2006	20c. Location - Cit	y or Town, State
Cate be executed Wedgical Examiner bhysicien and physicien and the burial-transit		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	,	1001,	Approximate Interval Between Onset and Death
BOX 6 death certif sattending of for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date o	f delivery Day Year
ecords, P.O. law requires that the as been signed by the	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1		ite to the cause of death?
The The page	Completed		24a. Was autop perfo 1 🗆 Yes	rmed dea	re autopsy findings available r to completion of cause of th? Yes 2 \sumbox No
on of ding Phys Atter this funeral din	ertification; To Be	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury 28b. Time of Section 1 Pending (Month, Day Year) 3 Injury 4 Injury 5 Injury 1 Per 2	ome 5 ☐ Resid	dence 6 Other (	(Specify)
Division  To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	O	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Tov	vn, State)	or Rural Route Number,
DIVI To the Hospitel or Al within 24 hours after or To the Funeral Direc	Medical	29a. Certifier  (Check only one)  1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one)  1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.  29b. Signature and title of certifier  29c. License number	rred at the time,	cause(s) and mannedate and place, and 29d. Date signed (A	due to the cause(s)
To with		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	5		-2006
S: Regis	tate trar	Len Butler 22 South Greene Street, Bult 31. Date filed (Month, Day, Year)  AUG 1 6 2006  AUG 1 6 2006	5, MD 2	1201	

State of Maryland / Department of Health and Mental Hygiene 2006 27478 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Nhu 12.100 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Director Yrs. 216-25-6816 Usual Residence of Decedent 88 Apr 14, 1918 Viet Nam r 28a-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? od other than "naturel", or items 23a or a event, the Medical Examiner must be re-USA 14. Race - American Indian, Black, White, etc. death 7314 Oskaloosa Dr 20855 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify δ 3√ Widowed 4 Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental 7 is marked of traumatic even Thinh Pham My Nguyen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other train once. Lien Le/Daughter 7314 Oskaloosa Dr. Rockville, MD 20355 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug 16, 2006 Silver Spring, MD Gate of Heaven Cem 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List poly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myocardial Acute Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attanding Physicien: The law requires that the death certificate be executed iche Due to (or as a consequence of): physicien a s the burial-Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by eprovascular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? this certificate 1 Yes 2 No 20 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2☐ER/Outpatient 3☐ DOA Other. 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Ratural death. 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funerel Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D59013 15825 Shady Grove Ad 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khludenev, M ROCKVIlle KONSTANTIN 31. Date filed (Month, Day, Year) State AUG 1 5 2006 Registrar

06-06107 Brian Wills

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 27479

			1- For State Registrar				Certific	ate of .	Death			R	eg. No.	2		2 141
	Physici		1. Decedent's Name (First, Middle,Last)  2. Da  Mo								2 Date of Dea Month		Year	3	3. Time of Death	
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	Francis		5. Social Security N		S. Sex	7 Ago (Is	n yrs. last bir	(hday)	If Under 1		If Under 24Hr	To Date of B				
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	or 28	Director											og Cilizei	TOTVITA	ii Courili	y,
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	death with the Maryland or items 23a or 28a-f sho	Funeral		ed 2 X Mar	ried Armed	Forces?		If Yes	s, specify C	uban, <b>N</b>	nic Origin / ( S lexican, Puert	pecify Yes or No Rican, etc.)	- 14	. Race - White,		an Indian, Black,
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036	ithin ne r than	립	10TH	[				MAINT	ENANC	E			I	PRIV	ATE	ĺ
7	Hygie other	흥	17. Father's Name	(First, Middle, L	ast)		•			18.	Mother's Nam	e (First, Middle,	Maiden Su	rname)		
21215 <u>-</u> 0036	lbe fi ental l rrked	Be	CLYDE WI									SELLERS				
ć	Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene fant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	မ	19a. Informant				118					Rural Route Nur	mber, City o	or Town,	State, Z	ip Code)
2	nd 2 s alth au m 27		HATTIE -M		MOTHER				ORIAN			LINTON,			_	
9	S l ar		20a. Method of Dis		3 Removal	from State	20b. Place of cremat	ory or othe		t cemet	ery,	Date	20c. Loc	ation - C	City or To	own, State
<u>.</u>	Page nent o		4 Donation 5	Other Spe	ecify:		WASHI	NGTON	NATI	ONA	L CEM.	8/23/06	st	JITL	AND,	MD
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	hysician /Medical		23a. Part I. Enter th failure. List on	ie disease, or c ly one cause o	n each line.					ring, su	ch as cardiac	or respiratory arr	est, shock,	or hear		Approximate Interval Between Onset and
	xaminer	- 1	Immediate Cause ( or condition resulting		a Compli			d inju	ries							Death
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	xecuted n and - transit	Exa	events resulting in	death) Last	Due to (or as	a conseque	ence of):								- 1	.03
	the death certificate be executed by the attending physician and ched for use as the burial - transi	an/Medical	X UNPENDED			19a r	er fh	2860	10-1	6-06	ó vt					
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Box 6	ath ce attend	Sici	1 Yes 2		01110	gnant at time	e of death	Othe	er (Specify)							
ă	he de y the	Physicia	Part II. Other signi		a Our	nown	A most something		d = 10		Double Comment	22- Did.			to to the	e cause of death?
0	that ned le deta	<u>\$</u>	. ure in Other Signi	mount conditio	onthibuting	to death bu	Chocresuling	g in the un	derrying cat	ise Give	minrani.				_	oly 4 V Unknown
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of Vital Records	ing Physician: The law requi After this certificate has been uneral director, page 2 should	ပ္	1 Yes  27 Manner of Deat	2 No	'_		2 V ER/O	utpatient Time of Inj				ng Home 5	Residence		Other.	
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Division	To the Hospital or Attending Physician: The I within 24 hours after death To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Certification:	3 Suicide 4 Homicide	6 Could determ	not be		idence	1111, 50,000,	ractory, on	ioc banc	arig, etc.	or Town, S	State) 85	02 D	orian	Route Number, City Lane
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	To the Hospital within 24 hours To the Funeral completely filled	Medical	one) 2		iner:On the basi	s of examina										
	To To	Me	29b. Signature and	title of certifier	and manner	stated.			29c Li	ense n	umber		29d Date	e signed	(Month	n, Day, Year)
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			30. Name and addr			use of death	(Item 23a)		- 1							
12	4	ŀ	Ling Li, MD		t Medical Ex		111 Peni	n Street	Baltimo	re, M[	21201					
		ate	31. Date filed (Mon			Registrar's S	Signature	1 4	_							
	Regis	rar	AUG	2 2 200	IG A	ر معد	# A	201/2	,							

			For 1 - State Registrar	State of Marylar		artment of H rtificate of I			giene Reg. No. 2	006	27480
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De		Year	3. Time of Death
	/Medic	al	ETHEL MAE	WILKERSON				Hug.	14	2006	1548 M
1	Examin	er	4a. Facility Name (If not institution, give str Plantauca Algiona)	eet and number) NAUM /WHA			r Location of Death	1		nty of Death	•
	Funeral		5. Social Security Number 6. Sex	7. Age (in yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birthp	lace (State or Foreign
	Director		216-05-6613	<sup>4</sup> 2 <b>∑</b> F 87	Yrs.	Months Days	Hours Min.	(Month, Da		Coun	ARDS, MD
	pur *		Usual Residence of Decedent  10a. State 10b. County	10c C	ty, Town or Lo	ocation					0d. Inside City Limits
	f show	ក	DELAWARE SUSSEX							1	1X Yes 2 □ No
	288-1	Director	10e. Street and Number	<u>5</u> .	ELBYVII	10f. Zip Code		· · · · · · · · · · · · · · · · · · ·	10g. Citizen o	of What Coun	
	3a or		31 NORTH MAIN ST	REET		1997	5				
	death	Funerai		. Was Decedent Ever in L Armed Forces?		Was Decedent of H	ispanic Origin? (S	pecify Yes or No	- 14. F	D STAT lace - Americ lack, White,	an Indian,
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "netural", or Itame 23a or 28a-f show event, I'm Medical Exacutaer must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:		1 ☐ Yes 2 <b>X</b> No	Specify:	o rican, etc.)		c <i>ify:</i> WHI	
21215-0036	2 hou	ted	15. Decedent's Educa	tion	16a. Dece	dent's Usual Occup	ation		16b. Kind of	Business/Ind	dustry
215	within 7 ene. than "n	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done o DO NOT use retired	during most of wor f)	king			ERATIONS
	filed with Hygiene other tha	Con	8		SH	IPPING CI				RICULT	URE)
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2	3 8 4 5	ဥ	DEWEY SOCKRITE  19a. Informant's Name/Relationship (Type		10h Mailie	ng Address (Street	ZENNA	TRUIT		un Ctata 7in	Codel
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ē,	一工革命		20a. Method of Disposition	20b.	and the same of th	sition (Name of matory or other place	4.1	Date		n - City or To	
Baltimore,	Page ent c nt: If ry or		1 X Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	SE]	BYVILL	E REDMEN'	SAUG	18,2006	SELBY	VILLE,	DELAWARE
Ba	permit. Pa Departmer Important: eny injury		21. Signature of Funeral Service/Dicensee	1A	W	ATSON FUNITELLSBORO	NERAL HOM				
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	itions that crused the dea	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a conse	quence of):	-1 477710	4.00				T WEEK 3
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	ed ist	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse		, , , ,	1				3 WEEKS
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	± 00 €	ledicai	<b>u.</b> .								
Вох	leath certi attending I tor use a	an/N	230. Was decedent pregnant	: If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy				Date of delive	
	The law requires that the death cert tile has been signed by the attendin bage 2 should be detached tor use	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at time of o		Other (specify)			'	Month	Day Year
P.0	that the		Part II. Other significant conditions contri	buting to death but not re	sulting in the u	nderlving cause give	an in Part I.	23e. Did to	obacco use co	ontribute to th	e cause of death?
of Vital Records,	uires tha signed I Id be det	d by	Pulmonany Fibrosis			, , , , ,			res 2 □ No		
Ş	w require s been si should I	Completed	PNEUMONIa					24a. Was	an 24t	. Were autor	psy findings available
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ital		Bec	25. Was case referred to medical				26. Place of Dea			1 1 105	2   NO
Ž >	d s	ToE	examiner? 1 Yes 2 XNo	spital: 1 X Inpatient 2	ER/Outpatien	it 3□ DOA Othe	er: 4 Nursing H	ome 5 Resid	dence 6 🗆 C	ther (Specify	,
D C	ding Ph h. Atter th funeral	ü.	27. Manner of Death  1. ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl		28d. Describe f	now injury occ	urred	
isic	Attending in death.	icat	2 Accident investigation 3 Suicide 6 Could not be	29 a Place of Injury - At h	omo form etc		Yes 2 □No	29f Location /	Stroot and Alum	nhar or Dura	I Bauta Mumbas
Division	al or A after i Direc d in by	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)	eet, ractory, onice		City or Tox	vn, State)	iiber or Hurai	l Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edicai (	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examine	r: On the best of my known of the basis of examination and manner stated.	owledge, death ation and/or inv	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	and due to the	cause(s) and a date and place	manner as sta e, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number		29d. Date sign	ned (Month, L	Day, Year)
•			Polat	$\sqrt{}$		D#23	522		08/1	4/200	6
	ва 4		30. Name and address of person who com	pleted cause of death (Ite	п 23а) (Туре,	Print) ShORE	n 51	6		801	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	7>/ 8/6/0. ature	SHOKE D	VIC. JAIS	DULY IN	9 01	001	
	Registr	ar	AUG 1 7 200	Jb Mayer	J. A.	nede					

State of Maryland / Department of Health and Mental Hygiene, 27481 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST 0455 FRANK POWELL WRIGHTSON III 18 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner EASTON HE MEMORIAL HOSPITAL ALBOT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month) Day, Year MAY 14, 1934 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□F MARYLAND Yrs. 72 Director 217-30-7957 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits items 23a or 28e-f ehor 1X Yes 2 No Directo TALBOT **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29712 AUSTIN LANE 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: δ 3 X Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TEACHER PUBLIC EDUCATION 12 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nd Mental h ESTELLE DAWKINS ၉ FRANK P. WRIGHTSON, JR. 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health an.
Important: If item 27 is m.
eny injury or other. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY T. WRIGHTSON/DAUGHTER 3927 SOUTH 6TH ST., ARLINGTON, VA 22204 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 8/19/2006 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Doseph FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 Ostroush CA.SP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ogset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** d /Medical Due to (or as a consequence of): Examiner hyelof be Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ( s a consequence of): Examine physicien and the burial-transit Due to (or as a consequence of): Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, been sig 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? hes autopsy performed? page 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funerei I filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29c. License number 29b. Signature and title of cepitier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) washington St. Easten murte 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygienes Reg. No. 2006 1 - For State Registrar 27482 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Jean Claudette Whisonant 100057 2000 7:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Doctors Hospital Lanham 8. Date of Birth (Month, Day, Year)
Mar. 27, 1933 Wash. D.C. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 💢 F 73 577-41-4120 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County r than "naturel", or Items 23s or 28s-f show the Medical Examinat must be notified at 10d. Inside City Limits M☐Yes 2 No Director Maryland Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12802 Whiteholm Drive 20774 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No à 3 ☐ Widowed 4 ☑ Divorced African American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. U.S. Treasury Dept. Account Technician 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: If item 27 is marked oth any injuy or other traumatic event ONCE. 18. Mother's Name (First, Middle, Maiden Sumame) Claude M. Jones Helen M. Hagood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (daughter) 12802 Whiteholm Dr., Upper Marlboro, MD Jelene Lee 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 9 1 XBurial 2 Cremation 3 Removal from State 8/16/2006 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service 7400 Ceorgia Ave. N.W., Wash. D.C. 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a. Rup Tured /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine iding physician and ise as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Certification: To Be Completed by Physician/Medical use as i 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 Pregnant at time of death signed by the at d be detached for 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No After this certific funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 × npatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifies Medical busis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) finer stated. 29b. Signature and title of ceptities 29c. License number 29d. Date signed (Month, Day, Year) 014182 08/09/06 apteted cause of death (Item 23a) (Type, Print) 6510 KENILWORTH AVE. SUITE 2500 KNERDALE NAFICY HAMMAD 31. Date filed (Month, Day, Year)
AUG 1 5 pgistrar's Signature State 2006 Registrar

HISONANI,

Box 68760.

of Vital Records, P.O.

Division

			1 - For State Registrar	State of Maryl		artment rtificate				Reg. No.	2006		+83
	Physici		Decedent's Name (First, Middle, Last     Donald Aloysius	Wetherbee					2. Date of De Month AUSUS		2006 <sup>ear</sup>	3. Time of <b>7:1</b> 8	
	/Medic Examin		4a. Facility Name (If not institution, give Holy Cross Hospit	al		4b. City, To	own, or Lo Lver	Spring	th		County of Death		
¢ ,	Funeral Director	5 0	5. Social Security Number 120-20-3912 6. So	9x 7. Age (In XM 2□F	yrs. last birthday) 79 Yrs.	If Under 1 Months		Under 24 Hrs Hours Min		, 192	9. Birth New	nplace (State or unity) York,	NY
	Maryland	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince G		. City, Town or Li Silver Sj							10d. Inside Cit	
	34 or 28	il Dire	10e. Street and Number 3152 Gracefield R	oad, #617		101. Zip C					zen ol What Co ed Stat		
350	filed within 72 hours after death with the Maryland Hygione. ther than "natural", or items 23a or 28a-f show int, the Madical Exam ar must be rediffed at	by Funeral Directo	11. Marital Status  1 □ Never Married 2□ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates Kone	in U.S. 13. ean War	Was Deceder		anic Origin? (§ Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	-	14. Race - Amel Black, White Specify:		
9500-6121	vithin 72 hou ne. han "neture e Medical E	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (9-4)2)	ucation	16a. Dece (Give life.	dent's Usual kind of work DO NOT use ign Set	done duri retired)	on ing most of wo	orking .er		nd of Business/l	·	ite
yiana z	× F F F S	To Be Co	17. Father's Name (First, Middle, Last) Dana Addison	Wet	herbee				me (First, Middle, Llizabeth			McDor	
Mary	es 1 and 2 should to of Health and Ment fitem 27 is marked rother traumatics	-	19a. Informant's Name/Relationship (1) Elaine Battle -co	Гуре, Print) PUS <b>i</b> N	19b. Maili 41 Oa	ng Address (S akmont	Street and Plac	Number or R ce Medi	ural Route Numbers, Penns	y lva	r Town, State, Z nia 190	ip Code) 63	
saitimore,	Pages 1 and nent of Health int: If item 27 ary or other to		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	ob. Place of Dispo cemetery, cre Rock Cred	osition (Name matory or oth ek Ceme	o of er place) etery	8/12	Date /2006		cation - City or I		
Part	permit. Pages Department of t Importent: If its any injury or o		21. Signature of Funeral Service Licen		of Bo	Name and	V. Bo wder	rgward Mill R	t Funera oad Belt	l Ho svil	me, PA le, Mar	yland 2	0705
	Physician /Medical Examiner		23a. Part1. Enter the disease, or composition, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olication of that caused the cone cause on each line.  Sepsis  Due to (or as a cone	death. Do not en							Approximate Interval Betw Onset and D	veen
á		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a cor	sequence of):								
68/60,	icate be executed physicien and s the burial-transit	icai	resulting in death) Last	Due to (or as a cor	sequence of):								
. BOX	the death certificate y the attending physiched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of prediction 1 Live birth 2 1 4 Pregnant at time 9 Unknown	Fetal death 3	⊒Ectopic preg ☐ Other (spec				2	23d. Date of delr Month		ear
coras, P.	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions of Acute Renal Failu				use given i	in Part I.			se contribute to		
Kec	The lay	Completed							1 ☐ Yes	rmed? 2 ☑ No	prior to death?	topsy lindings a completion of ca 2 \( \text{No} \)	vailable use of
VII	Physician: r this certifica rral director, p	o Be	25. Was case referred to medical examiner?  1 Yes 2 X No	Hospital: 1 X Inpatient	2 ER/Outpatre	nt 3 DOA	Other		ath <i>(Check only c</i> Home 5 - Resid		S □Other (Spec	ufu)	
	ng Phy ter thi	n: T	27. Magner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea			c. Injury at Work?		28d. Describe I				
	spital or Attending I ours after death. neral Director: After filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		At home, larm, st	M reet, lactory, o		s 2 No	28l. Location ( City or To	Street and vn, State,	d Number or Ru )	ral Route Numb	D01,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	ledicai C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my niner: On the basis of exar and manner stated.	knowledge, deat	th occurred at evestigation, is	the time, n my opini	date and plac ion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
		Me	29b. Signature and title of certifier	_ MD			License ni DO063				e signed (Month		
10	1+1		30. Name and address of person who is Irina Ruban, M.D.	2500 Forest	(Item 23a) (Type,	oad Si	lver	Spring	, Maryla	nd 2	0910		
·	Sta	te	31. Date filed (Month, Pay Year) AUG 1 5	32. Régistrar's S	ignature	barde						-	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 nn C

		For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artment <i>rtificate</i>	of Healt of Dea	h and M th		giene2	006	2748
		1. Decedent's Name (First, Middle, I	.ast)						2. Date of De.	ath	V	3. Time of Death
Physicia /Medic		ERNEST	An	NDOLE	50				Augus	+ 4 .	2006	11:01 AM
Examine		4a. Facility Name (If not institution, g	ive street and nu	-	200d		Own, or Locati			4c. Cou	inty of Death	
Funeral Director		218-36-0602	Sex 1 M 2 □ F	7. Age (In yrs	. last birthday) Yrs.	If Under Months	Year If Un Days Hou		8. Date of Bird (Month, Da Mar 1,	y, Year)	Cou	place (State or Foreign Intry) Land
and w	}	Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
hours after death with the Maryland tural', or Items 23a or 28a-f show at Examiner must be notified at	ō	MD			Balti							1 √2 Yes 2 □ No
28a-	Director	10e. Street and Number			Dalli	10f. Zip (	Code			10g. Citizen	of What Cou	intry?
3e or		3803 Colborne R	oad				21229				SA	,
E E	Funeral	11. Marital Status unk	12. Was Dec	edent Ever in U	U.S. 13.	Was Decede		Origin? (Spe	city Yes or No- Rican, etc.)	14. F	Race - Ameri	
	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced		2∭No ive	1	1 ☐ Yes 2			ncan, etc.)		Black, White cify: bla	
ical E	ted	15. Decedent's	Education		16a. Dece	dent's Usual	Occupation		unk	16b. Kind o	f Business/Ir	ndustry
ene. than "nat he Medici	Completed	(Specify only highest of Elementary/Secondary (0-12)		1-4or 5+)	life.	DO NOT use	done during r retired)	most or workir	ig .			
Hygien other th ent, the	ပ္ပ		unk								d ser	vice
avan svan	Be	17. Father's Name (First, Middle, Laternest Andol					18. M		(First, Middle,		,	
nd Menta marked umatic sv	၉								red Cro			
ealth and n 27 is n ier traun		19a. Informant's Name/Relationship Rodney Andoleo/b							Route Number		vn, State, Zij 21229	o Code)
nent of He int: if Item iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation _ 5 ☒ Other (Spec		State	Place of Dispo cemetery, cren	sition (Name natory or oth	e of ner place)	D.	ate	20c. Locatio	on - City or T	own, State
Department of Important: If It any injury or o		21. Sign a re of Fun ral Service Lice In a I d S		recto			Address of Fa natomy re, MD	Board 21201	655 W.	Balti	more S	Street
ysicien and Medical transit tr	i Examiner	23a. Part I. Enter the displase, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	caused the deapach line.  (or as a consection	quence of):	I DE	mIA		BRIL		001	Approximate Interval Between Onset and Death
been signed by the attending physishould be deteched for use as the I	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live I 4 ☐ Pregi 9 ☐ Unkn		nancy al death 3 death 5	Ectopic pre	gnancy cify)		Beit	23d. I	Date of deliv Month	ery Day Year
an signed		Part II. Other significant conditions	contributing to d	eath but not re	sulting in the ur	nderlying car	use given in Pa	art I.	23e. Did to			he cause of death? Dably 4 □Unknow
his certificate has be	Completed by								24a. Was autop	an 24l sy med? 2 <b>34</b> No	b. Were auto prior to co death? 1 \( \sum \section \text{Yes}	opsy findings available mpletion of cause of
ortificate has be	Be	25. Was case referred to medical examiner?					26. Pf	ace of Death	Check only or	-		20,10
his ce I dire	٥	1 ☐ Yes 2 ☐ No	Hospital: 1 🗆	Inpatient 2	ER/Outpatren	t 3 DOA	Other: 4	Nursing Hor	e 5 Resid	ence 6 □C	Other (Speci	5/)
After tunera	ë	27. Manner of Death  1 SNatural 5 □ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury		c. Injury at Work?	2	3d. Describe h	ow injury occ	urred	
tor: / the fu	cat	2 Accident investigate 3 Suicide 6 Could not	ha			М	1   Yes 2					
Direc in by	Certification;	4 Homicide determine	4 286. Place	of Injury - At h ing, etc. (Speci	nome, farm, str ify)	et, factory,	office	2	Bf. Location (S City or Tow		mber or Aura	al Route Number,
		CHOCK UTILY Z MOUICAI CX	Physician: To the	asis or examina	owledge, death	occurred at	the time, date	and place, a	nd due to the o	ause(s) and late and place	manner as s	tated.
thin 2	Medical	one) 29b. Signature and title of certifier	and man	ner stated.			License numb					
₹ 5 8		> Anna	Konc	an,	MO	250.	D57	728	4	29d. Date sign		Day, 48ar) 1 2006
		30. Name and address of person wh	KOR	NAN	M	0			•			
Stat Registra		31. Date filed (Month, Day, Year)  AUG 3 1 20	06	Registrar's Sign	ature	de						

06-06409

# Please Type or Print in Black Indelible Ink

Wayne Keith Alt State of Maryland / Department of Health and Mental Hygiene 1- For State 2006 27485 Certificate of Death Registrar Physician/ Decedent's Name (First, Middle, Last) Date of Death Medical Examiner 4a. Facility Name (if not institution, give street and number Month August 26, 2006 2301 hrs 4b. City, Town, or Location of Death c. County of Death 221 Adams Road Port Deposit Cecil **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Foreign Country) MARYLAND Hours 1 X M 2 F -462 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene iant: If item 27 is marked other than "natural", or items 23a or 28a-f she 1 Yes 2 No Director 10e. Street and Numbe 10g. Citizen of What Country Funeral Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 14. Race - American Indian, Black, Armed Forces White, etc Yes Divorced If Yes, Give Year ģ 1 Yes 2 No specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Medical Baltimore, MD 21215-0036 habor 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be ARCellus essue 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAVEN 21222 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Other Specify 9 CREMATOR Baltimore Signature of Funeral Se 22. Name and Address of Facility 2134 Willer Spring RD 23 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, Physician /Medical Approximate Interval Between Onset and Immediate Cause (Final disease a. Intrapral Gunshot Wound Examiner Death or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Examine Due to (or as a consequence of) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and trar Physician/Medical UNPENDED **AMENDED** Box 68760, attending phys IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 23d. Date of delivery Live birth past 12 months? Fetal death 3 Ectopic pregnancy Day Year Pregnant at time of death Yes 2 No 9 Unknown Other (Specify, the . g P. 0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð Completed 1 Yes 2 No 3 Probably 4 Unknown Records, 24a. Was an r this certificate has be al director, page 2 sh 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No Fo the Hospital or Attending Physician: 1 🗸 Yes Was case referred to medical No of Vital Be 26.Place of Death (Check only one) Hospital: 1 Other<sub>4</sub> 1 V Yes ER/Outpatient 3 No DOA Nursing Home 5 Residence 6 🗸 Other: Scene 28a Date of Injury After 27. Manner of Death 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division Aug 26, 2006 Natural death . 0000 hrs 5 Pending Subject shot self 1 Yes 2 V No Accident Investigation 3 V Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 Could not be 28f. Location (Street and Number or Rural Route Number, City To the Funeral or Town, State) 221 Adams Road, Port Deposit , Md determined Homicide (Specify) Mobile Home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Signature and title of cer 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E August 27, 2006 30. Name and address of person who completed cause of death (Item 23a) Lardn Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State AUG 3 gistrar's Signatur 2006 Registra

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State of Maryland / Department of Health and Mental Hygieney 27486 006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month JOHN FORD BARBOUR AUGUST 27, 2006 11:45 AM. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLOTTE HALL VETERANS HOME CHARLOTTE HALL ST. MARY'S If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1**万** M 2□ F Yrs. 8/31/1919 Director 218-07-9578 87 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. tnside City Limits or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo BALTIMORE COCKEYSVILLE 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 238 1240 PAPER MILL ROAD 21030 USA Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1XIYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 WHITE 1 Yes 2 No Specify δ Specify. 3 ☐ Widowed 4 ☐ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) RESTAURANT 5TH GRADE DISHWASHER other permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 I e marked othnery Injury or other traumatic event, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES BARBOUR REBECCA EATON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLAUDE BARBOUR/SON 13704 E. DEVONFIELD DR. BALDWIN. MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) MORELAND MEM. PARK 8/31/2006 HILLENDALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, TOWSON, MD 21286 8521 LOCH RAVEN BLVD. Part1. Enter the disease, or complications shock, or heart failure. List only one cause nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Hypernatremia
Due to (op as a consequence ol): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transit pertension Due to of as a consequence of) Box 68760 Completed by Physician/Medical ovona attending for use as 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown ģ Division of Vital Records, P. Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 3 Probably peeu 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an certificete 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this I Director; After this d in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification; 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) within 24 hours aft To the Funeral DI completely filled in To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) nun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Fredrick tospita Koaa 32/Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 3 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene. For State Registrar 27487 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Eileen Dorothy Busky **AUGUST** 28. 2006 4:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Nov. 11 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🕱 F 220-36-1923 88 1917 **Director** Maryland Usuat Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow 17 is marked other than "natural", or itema 23a or 28a-f ahor traumatic event, the Madical Examinar must be notified at Director Maryland Baltimore Baltimore 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4102 Taylor Avenue, Apt. 128 21236 u.s.A. Funerai Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, I □ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: White 3 ☐ Widowed 4 🛣 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) Bank Manager Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I Jacob S. Snyder Mary E. Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if item 27 is any injury or other traignes. Gregory Busky 8704 Fowler Avenue, Parkville, MD 21234 (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer 4 ☐ Donation 5 ☐ Other (Specify) 9/1/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes Buan 9705 Belair Rd., Baltimore, MD uill 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE HEMORRHAGIC STROKE /Medical Due to (or as a consequence of): Examiner OVERANTICOAGULATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 DEctopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) ned by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign. 1 Yes 2 No should a Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s 2 No 1 Yes 1 Yes 2/ 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation death. neral Director: A filled in by the fr 1 ☐ Yes 2 ☐ No 6 Could not be 3 Surcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) within 24 hours after d To the Funeral Direct completely fitled in by 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical o the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 08/28/06 D 31674 5 s of person who completed cause of death (Item 23a) (Type, Print) JEFFREY BERNSTEIN. M. D. . 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) State Registrar AUG 3 1 2006

	hysicia				Ce	rtificate of	Death	Mental Hyg	Reg. No. 2006	27488
E	/Medic xamin	al	Decedent's Name (First, Middle, Last,     Do inco.       Last,     Aa. Facility Name (If not institution, give)		В	eckne 4b. City, Town,	or Location of Deat	2. Date of Dea	Day Year 4c. County of Dea	
Fu	neral ector		The Johns H. 5. Social Security Number 6. Sec	opkins to	Spital nyrs. last birthday, 70 Yrs.	Balti	MUCC If Under 24 Hrs	8. Date of Birt	N/A h Year) 9. Bir 4.1935 I	thplace (State or Foreign ountry) LLINOIS
D		tor	Usual Residence of Decedent  10a. State 10b. County  VA WARREN		Dc. City, Town or L BENTON					10d. Inside City Limits 1 □ Yes 2 🛣 No
with the	the not	i Director	10e. Street and Number 98 LANDS RUN R	OAD		10f. Zip Code 226	510		10g. Citizen of What Co	buntry?
1215-UU36 within 72 hours after death with the Maryland ane.	roan navidal examiner must be notified at	by Funeral		12. Was Decedent Eve Armed Forces? 1  Yes 2 No Il Yes, Give Year or Dates:	r in U.S. 13.		Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No- to Rican, etc.)		e, etc.
	the Medical.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of wo		16b. Kind of Business	,
iryland should be file of Mental Hy	marked other matic event, I	To Be (	17. Father's Name (First, Middle, Last)  RONALD V. BEC  19a. Informant's Name/Relationship (Ty	KNELL	19b. Mail	ing Address (Stree	ANNA C	CATHERI	Maiden Surname)  NE DUFFY  or, City or Town, State, 2	Zin Code)
Department of Health ar	her trau		JEFFRA BECKNELL  20a. Method of Disposition  1  Burial 2 Commation 3	/DAUGHTER	615 20b. Place of Disp cemetery, cre BAYVIEW	PALOMA osition (Name of matory or other plate) I CREMAT	COURT, E	ENCINITA Date 5/06	AS, CALIFO	RNIA 92024 Town, State
Pnys	ician dical		23a, Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.						MD. 21231  Approximate Interval Between Onset and Death
	burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co		16	ERTIFICATION APPR	OVED BY MEDICAL	EXAMINER	3days
The taw requires that the death certificate that has been circled by the alterdal continues that	d be detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnanc	у		23d. Date of del Month	ivery Day Year
rdS, r quires that	should be deta	ed by Pl	Part II. Other significant conditions con		ot resulting in the w				obacco use contribute to	3
I Hecore: The law requ	page 2 sho	Completed	Mear V	egatative c	Stale, Ar	terior		24a. Was a autop perfor	sy prior to	topsy findings available completion of cause of 2 No
UIVISION OF VITAL RECORDS, I or Attending Physician: The law requires t after death of this continues has been since Diseases the this continues has been since Diseases.	e funeral director, page 2	ation; To Be	25. Was case referred to medical examiner? 1 Text s 2 No  27. Manner, of leath 1 Natural 5 Pending 2 Accident investigation	lospitat: 1 / Innatient 28a. D te of fnjury (Month, Day Ye	2 ER/Outpatie 28b. Time o Injury	of 28c. Inju	her: 4 🗆 Nursing H		ne) lence 6  Other ( <i>Spe</i> row injury occurred	cify)
UIVISIO  oital or Attendi  urs after death.	lled in by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of tnjury - building, etc. (S	Specify)			City or Tow		
To the Hospital or within 24 hours after To the Emercial Directions	completely filled in by the funeral	Medical	29a. Certifier (Check only one)  1	sician: To the best of m ner: On the basis of exe and manner stated.	amination and/or in	29c. Licens	opinion, death occu	irred at the time, o	cause(s) and manner as date and place, and due	to the cause(s)
	Sta	te	30. Name and address of person who con REHAN ONYOUM 31. Date filed (Month, Day, Year)	ompleted cause of death The Jh 32. Registrar's	(Item 23a) (Type	Print) ns Husy	oital bax	215.00 CN CN CN CN CN CN CN CN CN CN CN CN CN	e St Brito	FOSIS OM,

State of Maryland / Department of Health and Mental Hygien 2006 27489 1 - State Registrar Certificate of Death 2 Date of Death 3. Time of Death Name (First, Middle, Last) Month **Physician** 06:30 AM 2006 /Medical 4b. Gry, Town, or Location of Death Baltimore Examiner Universit edical enter lary land If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 30,1950 Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday **Funeral** Months 1 MM 2□ F 56 224-72-0360 Director MA Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 ie marked other than "naturel", or Iteme 23a or 28a-f ehow traumatic event, the Modical Examinar must be notified at 1 Yes 2 NO Director Anne Arundel Glen Burnie 10g, Citizen of What Country? 10e Street and Number 10f. Zin Code 1002 Linda Lee Drive #A U.S.A. 21061 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Slatus 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within timent of Health and Mental Hygiene.
 rtent: if Item 27 le marked other than College (1-4or 5+) Elementary/Secondary (0-12) 12 Construction Construction 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Joseph Bellon Margreat Bellon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1002 Linda Lee Drive #A GLen Mrs. Carol L. Bellon / Spouse Burnie, MD 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Sep. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State
4 ☐ Donard 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee = 5 permit. Page Department of Importent: If eny injury or 2006 Glen Haven Mem. Park Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral Home, Second Avenue SW Glen Burnie, MD21061 23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed Due to (or as a consequence of) physicien ar s the burial-t Physician/Medical use as the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ō in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Cther (specify) signed by the af P.O. 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 2 should Deen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an nes autopsy performed? page After this certificate Obacco 1 Yes 2 No of Vital or Attending Physicien: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 DOA funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide hours after To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29d. Date signed (Month, Day, Year) 29b. Signalore AU4176435P17451 who completed cause of death (Item 23a) (Type, Print) Kings ap Court Bllicott City MD 21042 4580 31. Date filed (Month, Day, Ye AUG 3 32. Registrar's Signature State 2006 Registrar

DHMH 17 Rev 1/2001

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State of Maryland	/ Department of Health	and Mental Hygiene 2	006	27

For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Helen Barbara Biddle August 27, 2006 3:00A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11060 Weymouth Court #209 Waldorf Charles Il Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days 1 ☐ M 2 🔀 F 75 Yrs. Director 037-22-4810 Feb.27,1931 Alabama Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1⊠Yes 2□No Directo Md. Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 11060 Weymouth Court #209 items 23a 20603 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ Specify:
Black þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Psychiatric Nursing Assist. St. Elizabeth Hosp 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked o 2 Jesse Esau Maggie Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11060 Weymouth Court #209

20b. Place of Disposition (Name of cemetery, crematory or other place)

20b. Place of Disposition (Name of cemetery, crematory or other place) Item 27 Jerome Biddle/husband 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Its eny injury or ot once. 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Md. Veterans Cem. | 9/5/06 Cheltenham, Md. 21 Signature of Funeral Service Licenseer 2. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 23a/ Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** Cardiovascular disease or condition resulting in death) Coroney Arky Disease /Medical Due to (or as a consequence of): Examiner Ki drew Chronic Kidn Due to (or as a consequence ol): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine ettending physicien and tor use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Lupus that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the e P.O. 9□ Unknown 9 Unknown certificate has been signed l rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. δ No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🙀 No 1 ☐ Yes 2 🔀 No After this certification, funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending within 24 hours after death.
To the Funeral Director: All completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of cartifie 29c. License number 29d. Date signed (Month, Day, Year) D0058686 08/31/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h NGLYEN , MD 6104 OLDBRANCH AVENUE TEMPLE HILLS MAKYLANN 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar AUG 3 1 2006

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		For State Registrar	State of Maryland	Departm Certific	ent of Health and ate of Death		g. No.	6 2749
Physiciar /Medica	n i!	1. Decedent's Name (First, Middle, Last)  EMORY			KER	2. Date of Death Month	Day Year 200	
Examine Funeral Director		4a. Facility Name (If not institution, give s  THE JOHNS HCPLI  5. Social Security Number  6. Sex  214-50-6372  Usual Residence of Decedent	IS HOSPITAL	- B	ider 1 Year   If Under 24 H	rs. 8, Date of Birth	4c. County of Dea	
natural, or items 23a or 286-1 ehow disal Examir at must be notified at stad by Euraval Director	ctor	10a. State 10b. County MA		Town or Location	re City			10d. Inside City Limits 1 ▼Yes 2 □ No
23a or 28e-fe		10e. Street and Number 3915 Callo	w avenu		Zip Code 21215	10	og. Citizen of What Co	
al', or items 23a or 28e-f ehow Examinar nast be notified at the Europeal Director	by runeral		<ul> <li>12. Was Decedent Ever in U.S Armed Forces?</li> <li>1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:</li> </ul>	3. Was De	scedent of Hispanic Origin? specify Cuban, Mexican, Pue s 2010 Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whi	
then "natura to Madical E	Сотріете	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	life. DO NO	Isual Occupation work done during most of w T use retired)	rorking	Newspa	/Industry
ked oth	9	17. Father's Name (First, Middle, Last)  James B	aker		18. Mother's N	ame (First, Middle, N	faiden Sumame)	
other treumet		19a. Informant's Name/Relationship (Ty) Vanderlean M	asen-leba	920	ess (Street and Number or I) Will d wood	RKuy 1	Pala, md	21229
5 5		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	CA CA	ace of Disposition ( metery, crematory)	or other place)		Dundal	
eny Injury page.		1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License  Vander learn	" Rinald A-A: Mancon-C	aysan <sup>22</sup> . Name	and Address of Facility nald A GRA	Lyson Fr	ineral Se	ivice
sician edical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.  OVERWHEL	Do not enter the r	node of dying, such as cardi	ac or respiratory arre	st,	Approximate Interval Between Onset and Death 48 Hours
rial-transit	LYB	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	ction ence of):				8 YEARS
for use a	II yaicidin Mi	in the past 12 months?  1 Yes 2 No 9 Unknown	Gc. If yes, outcome of pregnan 1	death 3□Ectopi ath 5□Other			23d. Date of de Month	Day Year
S P	2	Part II. Other significant conditions con	tributing to death but not resul	iting in the underlyin	g cause given in Part I.	1 ☐ Yes		obably 4 □Unknown
page 2		25. Was case referred to medical					ed? prior to death?	utopsy findings available completion of cause of
al direct	2	examiner? 1 ☐ Yes 2 ☐ No			DOA Other: 4 Nursing		nce 6 □Other (Spe	cify)
completely filled in by the funeral director, Medical Certification: To Be C	il III calloll	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  27. Natural 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hon building, etc. (Specify)	28b. Time of Injury M ne, farm, street, fac	28c. Injury at Work? 1 Yes 2 No	28d. Describe how	eet and Number or Ru	ural Route Number,
completely filled in		29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of my know er: On the basis of examination	rledge, death occurr on and/or investigat	ed at the time, date and plac ion, in my opinion, death occ	ce, and due to the car curred at the time, dat	use(s) and manner as te and place, and due	s stated. to the cause(s)
Idwoo		29b. Signature and title of certifier  OLCAY	AKSOY, MD		29c. License number RES - DOOT		d. Date signed (Mont	
		30. Name and address of person who co	TOHNS HOPKINS	23a) (Type, Print)	L,600 NORTH W	ULFE STREE	T, BALTIM	ORE MARYLAN 21287

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2006 27492

		•	For State Registrar	io or marytaira / E	Certificate of L	Death	Reg. N	2000	21432
*	Physicia	, in	Decedent's Name (First, Middle, Last)					ay Year	3. Time of Death
	/Medic	al	Nancy L.Brou		Ab City Tourn or	Location of Death	lugust:	22 ZOOK	
	Examin	٥, <u>-</u>	4a. Facility Name (If-net-Institution, give street a 1520 W. NORTH AVE.	APT 209	BALTI	MORE		N/A	
. T.	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. last bir	rthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth Month, Day, Year 8-0-1926	9. Birth Gay M	place (State or Foreign ARYLAND
	land	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
	Mary a-f ah	to	MD. N/A	BALT	TIMORE				1  Yes 2□No
	72 hours after death with the Maryland Insturet, or iteme 23s or 28e-f show dical Examiner must be notified at	ai Director	10e. Street and Number 1520 W. NORTH AVE.	APT 209	10f. Zip Code 21217	7	10g. C	itizen of Whal Cou USA	ntry?
	eme erre	Funerai	Arr	s Decedent Ever in U.S. ned Forces?	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Specify in, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ameri Black, White,	
5-0036	nours afte ural', or ti L'Examin	þ	1 Never Married 2 Married 1 If Ye  3 Widowed 4 Divorced Ye	]Yes 2 ∏No les, Give X ar or Dates:		Specify:			LACK
15-	n 72 h	lete	15. Decedent's Education (Specify only highest grade comp	oleted)	<ul> <li>Decedent's Usual Occupa (Give kind of work done of life. OO NOT use retired</li> </ul>	ation during most of working ()	16b.	Kind of Business/In	ndustry
2121	filed within Hygiene. ther then "	Completed	Elementary/Secondary (0-12) Co	ltege (1-4or 5+)	DOMESTIC	,	CR	OSSKEYS H	HOTEL
Maryland 2	d tal	To Be C	17. Father's Name (First, Middle, Last) HERBERT H. HAWKINS			18. Mother's Name (F MARY EL	irst, Middle, Maide		
lary	2 should and Men le marke eumatic		19a. Informant's Name/Relationship (Type, Pri		D. Mailing Address (Street				
	1 and Health em 27		LAVERNE BROWN (DAUGH 20a. Method of Disposition		1701 N. CARI of Disposition (Name of	EY ST. BALT		ARYLAND 2  Location - City or To	
mor	Pages nent of h int: If its iry or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	I from State cemeter	ory, crematory or other plac SON FOREST VI	θ)	200.	·	
Baltimore,	permit. Page Department Importent: Il eny injury o		21. Signalure of Funeral Service Licenses	NATHAN D. HIE	NEX. Name and Addres	ss of Facility PHILL MONROE ST	IPS FUNE	RAL HOME,	P.A.
1			23a. Part1. Enter the disease, or complication shock or heart failure. List only one cau.	s that caused the death. Do				ORE, TAKI	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Metastati	c urot	helial		noma	Onset and Death
67/	Examiner			Due to (or as a consequence	or):				
1	ed Isit	niner		Due to (or as a consequence	of):				
, <	rtificate be executed ng physician and as the burial-transit	Examiner	that initiated events	Due to (or as a consequence	of):				
68760,	ate be nysicia he bur	Medical	d						
	entifica ding ph	-	IF FEMALE:	es, outcome of pregnancy					
O. Box	iaw requires that the death ce as been signed by the attendir 2 should be detached for use	Physician/	in the past 12 months?	es, outcome of pregnancy  Live birth 2	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliv Month	ery Day Year
0	that the de ned by the a detached f		Part II. Other significant conditions contributions	ng to death but not resulling i	in the underlying cause give	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?
rds	w requires that s been signed t should be det	ed by	Renal Fally	re			1 🗆 Yes	2XNo 3□Pro	bably 4 □Unknown
Records,	sician: The law re s certificate has be- lirector, page 2 sho	Completed	Staphylocco	cus aure	is bacter	emia	24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ ✓	death?	opsy findings available ompletion of cause of
ita	entifica ctor. p	BeC	25. Was case referred to medical examiner?			26. Place of Death (C	Check only one)		
of Vital	Physician: r this certific ral director.	၉	1 ☐ Yes 2 No Hospita	1   Inpatient 2   ERVOL		er: 4 Nursing Home			fy)
	ding In. In. After tuner	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		Time of 28c. Injun Work	yat k? Yes 2 □ No	Describe how inj	ury occurred	
Division	or Attending after death. Director: Afte in by the fune	Certification:	a Could not be	Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f.	Location (Street a City or Town, Sta	and Number or Run ite)	al Route Number,
_	To the Hoepital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Co	(Check only Medical Examiner: O	To the best of my knowledge n the basis of examination ar id manner stated.	e, death occurred at the tin nd/or investigation, in my o	ne, date and place, and pinion, death occurred a	I due to the cause( at the time, date a	s) and manner as : nd place, and due :	stated. to the cause(s)
	Fo the within !	Me	29b. Signature and title of certifier		29c. Licens	e number		ate signed (Month,	
)		3	17 lang do	Januar	) D3	1586	A	ug 28	,2006
	$\wedge$		30. Name and address of person who complete		(Type, Print)	22 5,61	-eene	5+	10 1 40
· ta	Sta	to	31. Date filed (Month, Say, Year)	32. Registrar's Signature		Bathmo	ive,	Mary	19 nd 2/20
	Registi		AUG 3 1 2006	Van H	love.				

State of Maryland / Department of Health and Mental Hygiene 2006 27493 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August Carter, Jr. 2006 Richard G. 3:39 а м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Towson Baltimore If Under 1 Year It Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Apr 1 Days 7 Paris 1932 5. Social Security Number 9. Birthplace (State or Foreign New York 7. Age (In yrs. last birthday) **Funeral** Months Days 218-26-7140 XXM 2□F Yrs. Director Usuat Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23a or 28e-1 show ery injury or other traumatic event, its Mudical Examination. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Cockeysville 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21030 12150 Falls Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) Contractor Home Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Richard G. Carter, Sr. Viola M. Griffith ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12150 Falls Rd. Cockeysville, Md. 21030 Mrs. Jean M. Carter/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cem. 9-2-06 Pikesville, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Funeral Home: 21. Signature of Frigeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Noce Physician weeks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the deeth certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached fo 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t lirector, page 2 s autopsy performed? Yes 2010 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours effer death. To the Funerel Director: After this certifical the Funerel Director: After this certific mpletely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospic Hospital: ဦ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death Certification: 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2006 30. Name and address of person who completed cause of death (tem 23a) (Type, Pript)

AALON J. CHRUES M. (600 N. CHWES ST Brance No) J. Commes 31. Date filed (Month, Day, Year) 32. Agistrar's Signature State AUG 3 1 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 27494 State of Maryland / Department of Health and Mental Hygiene 2006 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yeer **Physician** 0300 AM oma 30, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner If Under 1 Year if Under 24 Hrs. 8. Date of Birth
Hours Min. April 27, 1948 New York Johns 6. Sex king rosp, ta 9. Birthplece (State or Foreign **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 1 □ M 2 □ F 055-42-4982 58 Yrs. Director Usual Residence of Decedent the Maryland 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2- No Director Harford Md. Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 5 1336 N. Fountain Green Road 21015 U.S.A. 238 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? FF∄Ves 2 □ No If Yes, Give Year or Dates: і І І І І Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced white "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry othar than Elementary/Secondary (0-12) College (1-4or 5+) design engineer fire alarm security 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) itam 27 is marked o Pages 1 and 2 should be Gwendolyn Stuttig Fredric Custance 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Catherine Custance/wife 1336 N. Fountain Green Road, Bel Air, Md. 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of himportant: If its eny injury or of once. 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Highview Mem. Gdns. 9/2/06 Fallston, Md. 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. MacPhail Road, Bel Air, Md. Immediate Cause (Final **Physician** o month disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by peq 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 1 Yes 2 XNo director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 📈 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 2 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 □ Yes 2 □ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours after To the Funaral Dir

State Registrar

Medicai

31. Date filed (Month, Day, Year) AUG 3 1 2006

R. Infante

29b. Signature and title of certifier

29a. Certifier

onel

Jeffrey

(Check only

M.D.

arte

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.O

🏗 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

600 North Wolfe Street Bultimore, MD 21287

State of Maryland / Department of Health and Mental Hygiene 200627495 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2006 Month **Physician** LESLIE KEITH CARTER Year AUG. 27 10:00PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4800 LAUREL AVENUE BALTIMORE CITY N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 1 **X**M 2 □ F 65 10/07/1940 Yrs. Director 218-60-9729 JAMAICA, Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits N/A BALTIMORE CITY MD Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 end 2 should be filed within 72 hours after death with ral', or Iteme 23a or Examiner must be 7 4800 LAUREL AVENUE 21215 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: BLACK 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than vent, the Max REAL ESTATE College (1-4or 5+) Elementary/Secondary (0-12) INSURANCE AGENT 12 YEARS INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BALKAN CARTER DORIS MCLISH ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6608 EBERLE DR, APT 201, BALTIMORE, MD TORRION L. CARTER/DAUGHTER 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Himportant: If ite any injury or of once. t ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/02/06 KING MEM. PARK WIDNSOR MILL, 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HEIGHTS AV, BALTIMORE, 21. Signature o 22. Name and Address of Facility FUNERAL HOME 21207 or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immed at Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner 145 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sicien and e burial-transit P.O. Box 68760, 🖒 Due to (or as a consequence of) Physician/Medical phys the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Cher (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably EASF24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy ormed? 1 Yes 1 ☐ Yes 2□ No Division of Vital 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1' Natural 5 ☐ Pending death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the within 24 hours after death To the Funerel Director: completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 27496 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 2:48 AM Linda Gay Cramer August 27. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Center Towson If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) B. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 63 214-38-6139 28,1942 Director Nov. Baltimore, MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show the Medical Evantion must be notified at 1 ☐ Yes ŽŽNo Laurel Director Delaware Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19956 108 Culver Court items 23a United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
Int: if item 27 is marked other then "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3 ☐ Widowed 4x Divorced Year or Dates: Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+) Verizon Salesperson 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ruby Dean 2 Charles Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21078 216 Smaty Jones Terrace Havre de Grace, MD Mark Cramer (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of important: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 9/1/2006 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 2a 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician nore months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physicien ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.0. Physi 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner-of Death 28b. Time of After t Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide filled in Hospital 1 🖯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and tiffe of pertifier 29d. Date signed (Month, Day, Year) 125 205 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charle St. Bolts MI 20205 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 1 2006 Derki Registra

			1 - For State Registrar	State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygie	2006	27497
	44 (A)	A.	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Audrey B. Davis				29, 2006	3:45 P <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give si		4b. City, Town, or Location of Deat	h	4c. County of Death	
	1		1214 Bolton Street		Baltimore		N/A	
	Funeral		5. Social Security Number 6. Sex	M 2 F 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Y	ear) Coun	* *
٠	Director		131-28-6850 Usual Residence of Decedent	72 Yrs.		Nov. 9,	1933 New	York
	/land		10a. State 10b. County	10c. City, Town or	Location		10	d. Inside City Limits
	Man,	to	MD N/A	Baltimor	e			N∑Yes 2 No
	or 28	Director	10e. Street and Number		10f. Zip Code	100	. Citizen of What Coun	ry?
	death with the Maryland me 23a or 28a-f show rmat be notified at	ai	1214 Bolton Stree	et	21217		USA	
		Funerai	The state of the s	Was Decedent Ever in U.S.     Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer</li> </ol>	specify Yes or No- to Rican, etc.)	14. Race - America Black, White, e	
9	filed within 72 hours after Hygiene. ther than "natural", or fte int, the Medical Examine	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	t ☐ Yes 2(1) No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	ni to	Specify:	
315-0036	tural	ed b	15. Decedent's Educ		edent's Usual Occupation	nite	Whit Sb. Kind of Business/Ind	
15	n na	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) (Giv	re kind of work done during most of wo DO NOT use retired)	rking		-0.07
7	d with giene er the	Completed	Elementary/Secondary (0-12)	5+ Cura	tor	S	mithsonian	
2	~ - 0 =	Be	17. Father's Name (First, Middle, Last)		18. Mother's Nar	me (First, Middle, Ma	uiden Sumame)	
yland	should be and Menta rmarked umatic av	2	George W. Blyman		Helen U	Jsewack		
Маг	0.00 = 0		19a. Informant's Name/Relationship (Typ		iling Address (Street and Number or Ri			
	as 1 and 2 should of Health and Men (Item 27 Is marke r other treumatic		Miles Davis - Hush 20a. Method of Disposition	pand 1214 20b. Place of Dis	4 Bolton Street Ba	Itimore,	Maryland 21 oc. Location - City or Tox	217
daltimore,	9 0 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State cemetery, ci	rematory or other place)		•	
	그 된 판 글		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	Metro Ci	rematory Aug.	31, 06_B	altimore, M	D
g	Deparim Important		Kim Do	blaman	<sup>22</sup> Name and Address of Facility Cremation Society 299 Frederick Ave	of Maryl	and, Inc	Ω
			23a. Pard. Enter the disease, or complic shock, or heart failure. List only one	cations that cause the death. Do not e	nter the fode of dying, such as cardia	or respiratory arres	t,	Approximate
•	Physician		Immediate Cause (Final	e cause on par line.	us lagenous !	U.Klm.	· 1	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to or as a consequence of):	Jewy L	2001 40100	6	monay
	Examiner		Sequentially list conditions b.	500	]()			
	ם ב	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	347			
	and and I-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):		-		
8/60,	icate be executed physician and s the burial-transit			Duo to (of as a consequence or).				
280		edicai	d.					
ROX	death certifi e attending p id for use as	Z/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy	_		23d. Date of deliver	v
ň	death e atte d for	Physician/M	in the past 12 months? 1 Yes 2 No	4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
5		hys	9 Unknown	9□ Unknown	<u> </u>			
'n	law requires that the der as been signed by the a 2 should be detached fo	by	Part II. Other significant conditions cont	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the	cause of death?
ecord	w require been si should b					1 🗆 Yes	2 No 3 □ Proba	ibly 4 Unknown
Ö	as be	Completed				24a. Was an autopsy	prior to com	sy findings available ipletion of cause of
ř	: The law cate has page 2	ပ္ပ				performe 1 ☐ Yes 2 €	d? death? 1 ☐ Yes	2 No
Vital	Physicien: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	Othor	ath (Check only one)		
Ö	Phy this	7: 10	1 ☐ Yes 2 😿 No  27. Manner of Death	28a. Date of Injury 28b. Time	of 28c. Injury at	10me 5 Residen	ce 6 Other (Specify	)
0	Attending or death.	tlor	1 ■Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
DIVISION	Attendi er death. actor: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural	Route Number.
ב	tal or	Cer		building, etc. (opeany)		Only or rount,	olato)	
	To the Hospital or Attendingth 24 hours after death. To the Funeral Director; A completely filled in by the fu	Medicai	(Check only 2 Medical Examin	ician: To the best of my knowledge, deer: On the basis of examination and/or	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the cau urred at the time, date	se(s) and manner as sta e and place, and due to	ited. the cause(s)
	thin 2	Med	29b. Signature and title of certifier	and manner stated.	29c. License number		I. Date signed (Month, E	
1			人。例	Mil- NUN			0.00	
•	1		0. ame and oddress of e son who con	nplefied cause of death (Item 23a) (Typi	a. Pribt) O 1 A	11	00. 00-	2006
	U		KODIRIGO PI	Uich-12401	W. Belvedene	AVE . TO	AltiMORE	MDRIRD
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature	neite	1 - 0 - 1 - 1		
33.3	Registi	rar	Atti a 1 ZUU!	I REPORTED AND STOP				

DHMH 17 Rev 1/2001

			America Items 23a	, D, 44c 11, 123 y 27	,28	Certificate of	0858',087 Death	29706dflb	Reg. No.	U 6	2/498
	Dhycici	an	1. Decedent's Name (First, Middle, Las	st)				2. Dete of De	ath		3. Time of Death
9	Physici /Medio		Frank G. Flint,					Month 0 7	Day	Year 2006	10:15
J	Examin	er	4e Fecility Neme (If not institution, give			-	0	r Location of Death		y of Death	
			University S 5. Social Security Number 6. S	pecialty F	lost his	hday) If Under 1 Year		timers		N/A	
	Funeral Director			ex 7. Age (In yrs. 54	iasi biri	rs. Months Days	Hours Mir	Sept. 2	th (1951)	9. Birthplac	ca (State or Foreign land
	g ,		Usuel Residence of Decadent								
	anyle show	'n	10a. Stete 10b. County Maryland Baltimo			orLocation more Highla	nde			10d	l. Inside City Limits
	the M	ect	10e. Street and Number								1 X Yes 2 □ No
	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show he Madical Examiner must be notitled at	Funeral Director	3015 Delaware Ave	<b>.</b>		10f. Zip Code 21227			10g. Citizen of U . S	Whet Country A.	7
	eme :	Iner	11. Marital Status	12. Was Decadent Ever in U Armed Forces?	,S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (	Specify Yes or No	14. Rac	ce - American	
20	s afte	Y.	1 ☐ Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 X No		no rican, etc.)		ck, White, etc y: Whit	
215-0020	2 hour	Completed by	15. Decedent's Ed	Year or Detes:	169	Decedent's Usual Occup	ation				
212	hin 7	plet	(Specify only highest gra- Elementary/Secondary (0-12)	de completed) College (1-4or 5+)		(Give kind of work done of life. DO NOT use retired	during most of wo	orking	16b. Kind of B	usiness/indus	лгу
7	filed wil Hygien of the the	Sol	0		Pa	inter			Н	ome Im	provement
yland 2	8 E 5 2	Be	17. Fether's Name (First, Middle, Last)					me (First, Middle,		пө)	
	should nd Men marke umatic	유	Leo M. Kindle, S		105	Mailine Address (Ctrast		ele M. Ow			
Σ	nd 2 s		Nancy L. Grewe,			Mailing Address (Street a 3015 Delawa:					
e,	of Her		20e. Method of Disposition	20b. P	lace of	Disposition (Name of	1	Date	20c. Location -		·
Ĕ	on = o		1 ☐ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	Removal from State Wes	st A	rundel Crem	ãtory	07-20-06	0den	ton, M	D
saitimore,	parmit. Par Departman Important: any injury once.		21. Signature of Funeral Servica Licens	see		22. Name and Addres Ambrose Fi	ss of Fecility	lome of I	anedown		
	00=60		of eleco ?	7		2719 Hamme	onds Fer	rv Rd. I.	ansdown		21227
<b>S</b> E:			23a. Part1. Enter the diseese, or comp shock, or heart failure. List only of	ilications that caused the death one cause on each line.	n. Do ne	ot enter the mode of dying	g, such as cardia	c or respiratory ar	rest,	Ar	oproximate terval Between
) '	Physician /Medical		Immediate Cause (Final	Sep.	_	•		1		Or	nset and Death
·	Examiner		disease or condition resulting in death)	0.		onsequence of):		-//			1 clay 3
	si ad	Examiner		- Mu	( ) :	Coma F	actur	•////		1	Edaye
	nificata be axecuted ng physicien end es the buriel-transit	хап	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	Due to (or	r es a co	onsequence of):		1/ hut		i	
00/00	a be a /sicier e buri	<u>8</u>	trial initieted events	C	72.01			- OVED BY MEDIC	AL EXAMINER	-	
8	number of physical control	S S	resulting in deeth) Lest	Due to (or	as e co	nsequence of):	CERTIFICATION AS	OPPROVED BY MEDIC		ļ	
S .	ith cer tendir or use	an/		d							
5	the a	Physician/	Part II. Other significant conditions con Seizure disor	ntributing to death but not resu	ilting in	the underlying cause give	en in Part I.	23b. Did to	obacco use cor	ntribute to the	e cause of death?
	mar n		Anoric Bra	ZA INJURY	NCC.	nead mjury	у	1□ Y	es 211 No	3 Probab	ly 4 Unknown
ָרָ בְּילְי	n sign	g p	C	, ,			-	24a. Wes e	n eutopsy	24b. Were	autopsy findings
2	aw red s bee 2 sho	Completed	Jacral 6	Vound				perfor	med?	availat comple of dear	ble prior to etion of cause th?
	ata he	E						1 U Y	es 2⊠No		es 2⊠′No
9	entific ector,	e R	25. Was case referred to medical examiner?					ath (Check only or	ne)		
5	this c	<u> </u>	1 X Yes 2 10 No			atient 3 DOA Othe	4LI Nursing F	lome 5 ☐ Reside			
5	After 1 funa		1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	UNKANOWAY Year)	UNK	Work Work	res 2 XNo	28d. Describe h	. 1		
2	r dea octor by the	Certification:	3 ☐ Suicide 6 🛣 Could not be determined	28e. Placa of Injury - At ho	me, fam			28f. Location (Si	reet and Numb	known er or Rural Ro	oute Number.
5	e logical d		4 - Homeide	building, etc. (Specify	701	→ Unknown		City or Town	n, State)	Unknowi	n.
1	The interpret Authorities to Authorities and the second of	edical	29a. Certifier 1 ☐ Certifying Physical Check only one) 2 ☐ Medical Exami	sfclan: To the best of my know ner: On the basis of examinati	vledge, o	death occurred at the time or investigation, in my op	e, date end place	, and due to the co	ause(s) and ma	nner es state	d.
40	o the	-	29b. Signature and title of certifier	end manner stated.		29c. License			9d. Date signed		
•				24 n - 3				0	07/11	s la	0.6
	()	;	30. Neme end eddress of person who co		23a) (T	/pe, Print)			- ( ) / 6	7/20	0 0
						01 S. Ca	cortes	St. Bo	eltima	ere, N	06 1D21230
	State Registra	e :	SERS LU ZERA - V B1. Dete filed (Month, Day, Year) AUG 2, 9, 2006	32. Registrer's Signa	ure	,				/	

FRANK

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State of Maryland / Department of Health and Mer	mand the series and	$\mathbf{n}$	11	
State of Maryland / Department of Health and Mer	ntai Hygienez	U	u	0
	7 3	-	~	~

			State of Maryland / Depa	artment of Health and N	n Copies A Nental Hygie	ene2006	27499
			1 - For State Registrar Cer	tificate of Death		J. No.	2,,,,,
	Dhysiai	200	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
-	Physici /Medic		Gloria Jean Finne		August 3	0,2006	3:55 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
	Funeral		1608 Colony Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Pasadena If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Anne Arı	
	Director		212-42-8401 1 M 2X F 61 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, ) Aug. 31,1	944 Co	hplace (State or Foreign ountry) MD
	pu .		Usuat Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo.	cotion			104 1-14 01-11-14
	Aaryla Febor	ō	MD Anne Arundel Pasadena	CALIOTT			10d. Inside City Limits 1 ☐ Yes 2X No
	28a-	rect	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Co	ountry?
	death with the Maryland me 23a or 28a-f ehow rouat be potified at	Funeral Director	1608 Colony Road	21122		.S.A.	
	-m-	Iner	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (Sp I Yes, specify Cuban, Mexican, Puerto		14. Race - Ame Black, Whit	
20	s afte	by Fu	1 ☐ Never Married 2 📉 Married 1 ☐ Yes 2 📉 No If Yes, Give 1	☐ Yes 2 No Specify:	, ,	Specify:	White
9500-61212	tural			lent's Usual Occupation	16	Sb. Kind of Business	Industry
2 0	hin 72 B. Bn "ne	plet	(Specify only highest grade completed) (Give life. L. Elementary/Secondary (0-12) College (1-4or 5+)	lent's Usual Occupation kind of work done during most of work OO NOT use retired)	ring		
	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "netural", or iteme 23a or 28a-1 ehow event, the Medical Extronmer cuat be notified at	Completed	12 Banki			Banking	
		Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam Julia	e (First, Middle, Ma	uiden Sumame)	
Maryland	2 should and Men is marke aumatic	2	William Medinger  19a. Informant's Name/Relationship ( <i>Type</i> , <i>Print</i> ) Spouse 19b. Mailin	g Address (Street and Number or Rur		City or Tourn State	Zin Cada)
_	17 a 2		or or or or or or or or or or or or or o	Colony Road Pasad			
e,	of Health item 27		20a. Method of Disposition  20b. Place of Disposition cemetery, crem	sition (Name of patory or other place)	Date 20	c. Location - City or	Town, State
Ĕ	Page ment cant: if ant: if ury or		4 Donation 5 Other (Specify) Mausoleum Cedar Hil		6, 1	Brooklyn,	MD.
Баптітог	permit. Pages 1 and Department of Heali Important: if item 2 any injury or other once.					Funeral Ho	
	005 # Q		7 777	Second Avenue SW			
			23a. Paft 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	or the mode or dying, such as cardiac	or respiratory arres	ι,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a	gre faiture			
	Examiner		Immediate Cause (Final disease or condition resulting in death)  a	1 Disease			
^	Q #	ner					
<b>.</b>	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last				
, oo,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	calE	235 to (0, 43 2 35) 359(35) 150 (1),				
9	tificate ig phy as the		u.				
X Q	th cer tendir rr use	an/N	IF FEMALE: 23b. Was decedent pregnant 1	Ectopic pregnancy		23d. Date of del	•
	the death certifical y the attending phi ched for use as th	Physician/Med	in the past 12 months? 1 □ Yes 22 No 9 □ Unknown  in the past 12 months? 4 □ Pregnant at time of death 5 □ 9 □ Unknown	Other (specify)		Month	Day Year
7.	that the ed by detac	Ph	Part II. Other significant conditions contributing to death but not resulting in the un	deriving cause given in Part I.	23e. Did tobar	cco use contribute lo	the cause of death?
cords,	requires that sen signed b hould be deta	d by		, ,	1 ☐ Yes	2 □ No 3 □ Pr	obably 41 Hnknown
S S S S S	law rec as beer 2 shou	plete			24a. Was an		topsy findings available
Ĭ.	sicien: The law s certificate has b lirector, page 2 s	Completed			autopsy performe 1 Yes 2 €	d? death?	completion of cause of
<u>I</u>	entifica	Be	25. Was case referred to medical examiner?		h (Check only one)		
5	Physi this c	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Oulpatient				cify)
	ding h. After funer	tion	27. Manngr of Death 28a. Date of Injury 28b. Time of (Month, Day Year) 2 Accident investigation	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
DIVISION	Atten r deal ector: by the	flca	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre			et and Number or Ru	ral Poute Number,
5	tal or	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	State)	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only 2   Medical Examiner: On the basis of examination and/or inv	occurred at the time, date and place, estigation, in my opinion, death occurr	and due to the caus	se(s) and manner as	stated.
	ithin 2 the I	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number		. Date signed (Monti	
	5 7 8 7	Ī					* '
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print)		1019113/	/
	Ð		Anita Khandelwal MD, 3001, S.	outs Hanover St	Baltuno.	1 MD 21	225
ı	Sta Registr		31. Date filed (Month, Day, Year)  AUG 3 1 2005  32 Registrar's Signature	M .			
	, riegioti		nouvillo Alegan La Con	acts 1			

DHMH 17 Rev 1/2001

06-06056 Morris Fisher

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Ce	ertifica	te of l	Death					Reg. N	<u>.</u> 21	JUt	) (	1201
Physicia		1 Decedent's Name (First, Mic										Date of D Month				B. Time of D	
edical Exami	ner	Morris Fish					- 1.0	0:: =			/	August	15, 20	06		0652 h	rs
A		4a. Facility Name (if not institute Bon Secour Hospita		reet and ni	umber)		40	Baltimo		ocation of	Death			4c. County of	Death		
Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.	s. last birthday) If Under 1 Year If Under 24Hrs					24Hrs.						e or
Director		220-86-3357	1 X M	2F	4	40	Yrs.	Months	Days	Hours	Min.	Nov 2	25,	1965	Foreign Coun	<sup>itry</sup> Mary	land
· .		Usual Residence of Decedent			Tie en						11						
w an		10a. State 10b. Count	у		10c. City	, Town o										0d Inside	
yłand a-f she t once	tor	MD  10e. Street and Number				ват	imor	10f. Zip C	ode				10a C	Itizen of Wha		21	2
21215-0036  Jud be filed within 72 hours after death with the Maryland  Mental Hygiene Han "natural", or items 23a or 28a-f show any re event, the Medical Examiner must be notified at once.	Director	1022 Poplar (	Grove	Stree	et			TOI, ZIP C	ouc	212	16		Tog C	US		ут	
with the second of the second		11. Marital Status	1	2 Was De	cedent Ever in L	J.S.	13. Was	Decedent	of Hispa			ify Yes or	No-			n Indian, 8	lack,
death or iten	Funeral	1 X Never Married 2	Married	Armed F	orces?		If Yes	, specify	Cuban, N	Mexican, F	Puerto Rio	can, etc.)		White,	etc.		
s after ral", o			01	Yes, Give Yes	ar			es 2	-					Specify: 1			
hour:	Completed by	<ol> <li>Decedent's Education (Sp Elementary/Secondary (0-12)</li> </ol>		College (						n (Give kir OO <b>N</b> OT u			16b	. Kind of Bus	iness/Ind	dustry	
36 Jhin 72 Je. than edical	ηple	12	.,	0	1 10101	die	sab1e	h						none			
5-0C ed will tygien other	Con	17. Father's Name (First, Midd	e, Last)			1 41.	Japic	-u	18	Mother's	Name (F	ırst, Mıddle		en Surname)			
21215-0036 build be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Be	Frederick Fis		Egopus.						Elain							
D 2. should and M. 7 is ma	7	19a. Informant's Name/Relatio				1.7								City or Town			
and 2 sho lealth and ten 27 is		Stephanie Was 20a Method of Disposition	sning	/ aunt	20b.	Place of	Dispositi	on (Name	of ceme	tery.	Stre	et Ba	1 <b>1ti</b>	more,	MD City or To	21216 own, State	<u> </u>
Baltimore, MD 21215-0036 pernit Pages I and 2 should be filed within 1 begarinent of Health and Mental Hygien than Important: If tiem 27 is marked other than injury or other traumatic event, the Medicingury			-	Removal fi	t t	cremator	ry or othe	r place)							•		
nit Pa artmer ortan		21. Signature Funeral Service Ronal C	Specify: ce_licen	2/1			22. Naj	me and A	ddress o	f Faci <u>lit</u> y							
Dep Dep	1	( Kolland	10	th	Directo:	r		e Ar imor			oard 1201	655 V	<b>V.</b> В	altimo	re S	Street	-
Physician	•	23a. Part I. Enter the disease, failure List only one caus	or complica se on each	ations that of line.	caused the deatl	h. Do not	enter the	mode of	dying, su	ich as car	diac or re	spiratory	arrest, s	hock, or hear	rt	Approxima Between (	
/Medical Examiner		Immediate Cause (Final diseator condition resulting in death)			c ketoaci											De	
			b.	e to (or as a	a consequence	of):									- 1		
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus		e to (or as a	a consequence	of):											
	Examiner	(Disease or injury that initiated events resulting in death) Las	- C	e to (or as a	a consequence	of):	-				_						
executed an and al - transit			d														
ਭ ਫ਼ੋਫ	n/Medical	X UNPENDED		MENDED	item#23	a.27.1	perME.	.e859.	9/1/2	2006 T	T						
Sox 68760, death certificate be executed at the execution of the execution	/Me	IF FEMALE: 23b. Was decedent pregnant in	Ale -	23c. If yes,	outcome of preg	gnancy				Ectopic			2	3d. Date of c	-		
x 68 h certi tendin use as	iciar	past 12 months?			nant at time of d		Feta	death r (Specif		_Ecopic p	pregnancy	у		Month	Day	У	Year
, P.O. Box 68.  ires that the death certification is signed by the attending be detached for use as it.	Physicia			9 Unkn													
P.O.	by P	Part II. Other significant cond	litions co	entributing t	o death but not	resulting	in the und	derlying c	ause giv	en in Part	: I.			o use contrib	_		
S, F quires en sign												24a Wa		No 3			
cords, law requir has been s	Completed											aut	opsy formed	pr		psy findings npletion of	
tal Rec tian: The certificate ector, page	Con											1 Ye	2 🗸		Yes	2	No
Vital ysician: his certif director,	Be	25. Was case referred to medi examiner?		pital:	Inpatient 2	ER/Out	nationt	_		f Death (C	Nursing H		Poeis	dence 6	Other		
of Vital Records, ling Physician: The law requir After this certificate has been s funeral director, page 2 should	. To	1 Yes 2 No 27. Manner of Death			e of Injury h, Day, Year)		me of Inju			at Work?				njury occurre	,		
ion (tending eath.	tion		nding	(Mont)	n, Day,Year)				1 Ye	s 2 N	No						
Division tal or Attendi 15 after death. 19 Director: /	ifica		estigation uld not be	28e Plac	ce of Injury - At h	nome, farr	m, street,	factory, c	ffice buil	lding, etc.	28	f. Location or Town		and Number	or Rural	Route Nur	mber, City
Division of Vital Hospital or Attending Physician: 24 hours after death. Tenneral Director: After this certifully filled in by the funeral director.	Certification:	4 Homicide	termined	(Specify)	)							or rown	, state)				11
Divis  To the Hospital or A within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a Certifier 1 Certifying one) 2 Medical E			st of my knowled of examination												
To To COIT	Mec	29b Stoppature and title of cert	ar	nd manner :					icense r					I. Date signe			)
		(A. ().	Don '		KORD 1	r			D.C.M.	.E.				igust 15, 2			
		30. Name and address of pers	on who con	npleted cau	ise of death (Iter	n 23a)		<u> </u>									
		Patricia Aronica-Pol	ak MD.		ant Medical		ner 1	11 Per	n Stre	et, Balt	timore,	MD 212	01				
S Regis	tate trar		,		<b>eg</b> istrar's Signal	ture	108	de la									